Department of Health and Human Services

Fiscal Year 2010
Budget in Brief

May 7, 2009

Department of Health and Human Services
200 Independence Avenue S.W., Washington, D.C. 20201

This document also available at http://www.hhs.gov/asrt/ob/docbudget/2010BudgetInBrief.pdf

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ADVANCING THE HEALTH, SAFETY, AND WELL-BEING OF OUR PEOPLE

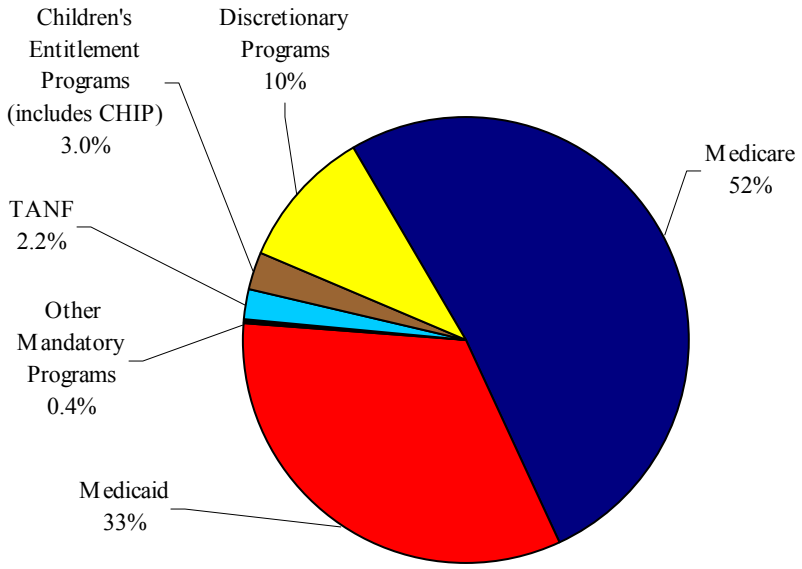
FY 2010 President's Budget for HHS

(dollars in millions)

	2008	2009	2010	2010 +/- 2009
Budget Authority (excluding Recovery Act).....	720,639	776,695	828,292	+51,597
Recovery Act Budget Authority.....	-	64,165	44,351	-19,814
Total Budget Authority.....	**720,639**	**840,860**	**872,643**	**+31,783**
Total Outlays.....	**698,847**	**816,198**	**879,196**	**+62,998**
Full-Time Equivalents.....	64,509	67,403	69,919	+2,516

Composition of the FY 2010 Budget

$879 Billion in Outlays



General Notes

Detail in this document may not add to the totals due to rounding.

Budget data in this book are presented "comparably" with the FY 2010 Budget, since the location of programs may have changed in prior years or be proposed for change in FY 2010. This is consistent with past practice, and allows increases and decreases in this book to reflect true funding changes.

In addition – consistent with past practice – the FY 2008 figures herein reflect final enacted levels.

ADVANCING THE HEALTH, SAFETY, AND WELL-BEING OF OUR PEOPLE

The Department of Health and Human Services enhances the health and well-being of Americans by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.

The Department of Health and Human Services (HHS) Budget, consistent with the President's goals, invests in health care, disease prevention, social services, and scientific research. These investments will improve the lives of children, families, and seniors by creating a healthy foundation for everyone to fully participate in the American community.

The President's FY 2010 HHS budget totals $879 billion in outlays, an increase of $63 billion over FY 2009. The Budget proposes $78 billion in discretionary budget authority for FY 2010. The Budget also proposes legislation to support activities that received about $2 billion in FY 2009 discretionary appropriations, mostly as emergency funding, with mandatory funding beginning in FY 2010. As a result, on an accounting basis, the HHS discretionary budget request declines by $166 million even though discretionary programs increase by nearly $2 billion outside the programs benefiting from the proposed mandatory legislation.

As described in this section, the ***FY 2010 President's Budget*** invests in key HHS priority areas to fulfill the President's health care vision by continuing on the path to health reform and building on the American Recovery and Reinvestment Act of 2009 (Recovery Act).

The President's proposed reserve fund for ***Health Reform*** (refer to the following section) invests in developing a long-term path to affordable, quality health care for all Americans.

The Department's portion of the ***American Recovery and Reinvestment Act of 2009*** (refer to the section following ***Health Reform***) addresses and responds to critical challenges in our health care system through investments that immediately impact the lives of Americans.

FY 2010 PRESIDENT'S BUDGET

The following goals and initiatives are highlights of the President's vision for a healthier, safer, and more prosperous America. HHS will continue to seek improvements and strive to exceed expectations in the following endeavors:

- Securing and Promoting Public Health;
- Delivering Human Services to Vulnerable Populations;
- Investing in Scientific Research and Development; and
- Improving Quality of and Access to Health Care.

SECURING AND PROMOTING PUBLIC HEALTH

Advancing Food Safety: The Budget includes an additional $511 million for the Food and Drug Administration (FDA), the largest increase ever requested, with $259 million of the increase devoted to food safety efforts. This funding level would increase and improve inspections, domestic surveillance, laboratory capacity, and domestic response to prevent and control food borne illness. FDA will increase the number of food inspectors by approximately 20 percent in FY 2010.

Lowering Drug Costs: The Administration is committed to lowering the costs of drugs for all Americans. The FY 2010 Budget creates a new pathway to approve generic biological products, supports FDA's efforts to establish a framework to allow the importation of safe prescription medicines from other countries, and provides for an industry funded user fee for generic drug review.

Preventing and Treating HIV/AIDS: The FY 2010 Budget includes $3 billion, an increase of $107 million above FY 2009, in the Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA) to enhance HIV/AIDS prevention, care, and treatment. The increase includes an additional $53 million for CDC to support domestic HIV/AIDS testing and surveillance, capacity building, and HIV prevention activities among high-risk groups. Within HRSA, an additional $54 million is included for the Ryan White HIV/AIDS program to increase access to health care among uninsured and underinsured individuals living with HIV/AIDS and to help reduce

HIV/AIDS related health disparities.

Addressing Autism Spectrum Disorders: The President is committed to providing an additional $1 billion over the next eight years to expand support for children, families, and communities affected by autism spectrum disorders (ASD). The FY 2010 Budget includes $211 million across HHS for ASD research, treatment, screenings, surveillance, public awareness, and supportive services.

Reducing Health Disparities: The FY 2010 Budget includes $354 million for combating health disparities to improve the health of racial and ethnic minorities, and low-income and disadvantaged populations. These funds include $143 million for the Minority AIDS Initiative under the Ryan White Act, $116 million for Health Professions and Nursing Training Diversity Programs, $56 million for the Office of Minority Health, and $40 million for the CDC Reach program.

Protecting Against Pandemic Influenza: Reassortment of avian, swine and human influenza viruses has led to the emergence of a new strain of H1N1 influenza A virus, (2009 – H1N1 flu) that is transmissible among humans, and as of April 28, 2009 is confirmed to have caused infections in humans in Mexico, the United States, Canada, Spain, and the United Kingdom. On April 28, 2009 the President announced a supplemental request of $1.5 billion for the Federal response to this outbreak. These funds, in addition to the FY 2010 Budget request of $584 million and the remaining balances, will allow HHS to develop, produce, and distribute antivirals, vaccines, personal protective equipment, and other medical counter-measures, as well as conduct public health surveillance and response efforts in the face of the current outbreak.

Supporting Advanced Development: The FY 2010 Budget includes $305 million for Advanced Research and Development to sustain the support of existing next generation countermeasure development in the high priority areas for anthrax, enhanced biothreats, and acute radiation syndrome. The funding for advanced research and development for FY 2010 will be provided through a transfer of funds from the BioShield Special Reserve Fund.

Improving the Quality of Emergency Care Systems: The FY 2010 Budget includes $10 million for a new Emergency Care System program, which will improve the quality of emergency rooms at regional hospitals, and set national standards. This initiative will develop national standards for emergency care performance measurement, and will support a demonstration program to improve the quality of operations and outcomes and regional emergency medical systems.

DELIVERING HUMAN SERVICES TO VULNERABLE POPULATIONS

Zero to Five Plan: The FY 2010 Budget sustains critical support for the President's "Zero to Five" plan for young children and their families by building on investments made in the Recovery Act.

Investing in Head Start and Early Head Start: Due chiefly to one-time Recovery Act funding, Head Start will serve 978,000 children in FY 2009, an increase of approximately 70,000 over FY 2008. Approximately 115,000 infants and toddlers, nearly twice as many as in FY 2008, will have access to Early Head Start services in FY 2009 and FY 2010. The FY 2010 Budget requests an additional $122 million to enable Head Start to sustain the FY 2009 increase in children served in FY 2010.

Expanding Home Visitation Programs: The President's FY 2010 Budget includes a legislative proposal for a new mandatory program which would provide funds to States to establish and expand evidence-based home visitation programs for low-income families. The FY 2010 Budget assumes $124 million in budget authority and $87 million in outlays, with the program growing to $1.8 billion in outlays in FY 2019.

Home visitation is an investment that can have substantial effects on outcomes such as child health and development, readiness for school, child maltreatment, and parenting abilities to support children's optimal cognitive, language, social-emotional, and physical development. Research including several randomized control trial studies showed one model of home visitation using nurses resulted in Medicaid savings from reductions in preterm births, emergency room use, and subsequent births. The proposal

is estimated to save Medicaid $664 million over 10 years, including $189 million in 2019.

Preventing Teen Pregnancy: The Budget provides $178 million in funds for teen pregnancy prevention programs to address rising teen pregnancy rates. Funds will support State, Tribal, Territory, and community-based efforts to reduce teen pregnancy using evidence-based models as well as promising programs that require further evaluation.

Expanding Drug Courts: The Administration is requesting an increase of $35 million to expand the treatment capacity of drug courts. Drug courts use close supervision, drug testing, sanctions, and incentives to ensure that offenders stick with their treatment plans and refrain from further criminal activity.

Within the increased funding for drug courts, $5 million will support families affected by methamphetamine abuse. Depending on their individual needs, children will receive early intervention and prevention services, mental health and child counseling, and other services to improve their safety and well-being.

Reducing Long-Term Foster Care: There is a substantial need for innovative approaches to improve outcomes for children languishing in foster care. The Budget request includes $20 million to fund projects that will implement and sustain evidence-based or evidence-informed practice improvements. Additionally, grantees demonstrating an improvement in child and family outcomes will be eligible to receive bonus funding.

Providing Home Energy Assistance for Low-Income Families: The FY 2010 Budget requests $3.2 billion for the Low-Income Home Energy Assistance Program (LIHEAP), the largest LIHEAP funding request for any year except the most recent when the Nation was threatened with an unprecedented increase in energy costs. Energy prices are volatile, making it difficult to match funding to the needs of low income families. For this reason, the Budget includes a legislative proposal to provide additional mandatory LIHEAP funding if energy prices increase significantly.

IMPROVING QUALITY OF AND ACCESS TO HEALTH CARE

Increasing Child Health Care Access: The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), signed by the President on February 4, 2009, extends the Children's Health Insurance Program (CHIP) through 2013 by providing an additional $44 billion to increase enrollment. CHIP enrollment between FY 2008 and FY 2013 is estimated to increase from 7.9 million to over 12 million children.

Enhancing Medicare and Medicaid Integrity: The FY 2010 Budget invests $311 million in discretionary resources to strengthen program integrity activities within the Medicare and Medicaid programs, with particular emphasis on greater oversight of Medicare Advantage and the Medicare Prescription Drug program. Reducing fraud, waste and abuse in government spending is a top priority for the Administration, and this investment represents the first year of a multi-year strategy.

These funds will augment existing mandatory resources for combating health care fraud and abuse. Moreover, the additional funding will better equip the Federal government to minimize inappropriate payments, pinpoint potential weaknesses in program integrity oversight, target emerging fraud schemes by provider and type of service, and establish safeguards to correct programmatic vulnerabilities.

Strengthening Medicare Sustainability: The Administration is committed to strengthening Medicare's long-term sustainability. The FY 2010 Budget bolsters the Medicare program by aligning incentives toward quality, promoting efficiency and accountability, and encouraging shared responsibility. Containing Medicare cost growth is not only essential to preserving the Medicare Trust Funds, but it also is a fundamental component of systemic health care reform.

Strengthening the Health Professions Workforce: The FY 2010 Budget includes over $1 billion to support a wide range of programs to strengthen and support our Nation's health care workforce. These investments will expand loan repayment and scholarship programs for physicians, nurses, and dentists who are committed to practicing in medically underserved areas. Additionally, this funding will enhance the capacity of nursing schools, increase access to oral health care through dental workforce development grants, target minority and low income students, and place an increased

emphasis on ensuring that America's senior population gets the care and treatment it needs.

Within this total, the Budget includes $330 million, an increase of $136 million for programs that are part of the President's initiative to address the shortage of health care providers in underserved areas. Programs included as a part of the President's initiative are the National Health Service Corps, the Nurse Loan Repayment and Scholarship Program, State Oral Health Workforce Program, and the Nurse Faculty Loan Program.

Improving Access to and Quality of Rural Health: The President shares HHS's belief in increasing access to health care and improving the quality of health care in rural areas. The FY 2010 Budget includes $73 million for a new "Improve Rural Health Care" initiative. The initiative includes increased funding for Rural Health Care Services Outreach, Network, and Quality Improvement grants ($55 million); services provided by State Offices of Rural Health ($9 million), and Telehealth grants to expand the use of telecommunications technologies ($8 million).

Improving Health Outcomes of American Indian and Alaska Natives: The FY 2010 Budget includes nearly $5 billion for the Indian Health Service (IHS), an increase of $454 million. This represents a significant investment, and will support and expand the provision of health care for American Indians and Alaska Natives. The increase will focus on reducing health disparities, supporting Tribal efforts to administer programs at the local level, and ensuring that where necessary, IHS services can be supplemented with care purchased from outside the Indian health system. The Budget affirms the President's commitment to improve health outcomes for American Indian and Alaska Native communities, and reflects a balance with funds provided for construction, equipment, and infrastructure in the Recovery Act.

Advancing Comparative Effectiveness Research: The FY 2010 Budget supports HHS-wide comparative effectiveness research, including $50 million within the Agency for Healthcare Research and Quality (AHRQ). This research will improve health care quality by providing patients and physicians with state-of-the-science information on which medical treatments work best for a given clinical condition. The National Institutes of Health (NIH) is also a significant contributor to comparative effectiveness research. The Recovery Act provided $1.1 billion for comparative effectiveness research. Agencies will continue utilizing these funds in FY 2010.

Enhancing Health Information Technology: The FY 2010 Budget advances the President's health IT initiative and accelerates the adoption of health information technology – an essential tool to modernize the health care system – and the utilization of electronic health records (EHR). The Office of the National Coordinator for Health Information Technology (ONC) will continue its current efforts as the Federal health IT leader and coordinator. This role will be vital to the President's health IT initiative. During FY 2010, HHS will also prepare to provide Recovery Act incentive payments beginning in 2011 to physicians and hospitals using certified EHRs.

INVESTING IN SCIENTIFIC RESEARCH AND DEVELOPMENT

National Institutes of Health: The FY 2010 Budget request of nearly $31 billion for NIH maintains a strong commitment to biomedical research, and builds on the unprecedented $10.4 billion in total provided to NIH in the Recovery Act. Within this total, more than $6 billion will support cancer research across NIH. This funding is central to the President's sustained plan to double NIH cancer research over eight years. In FY 2010, NIH estimates it will support a total of 38,042 research project grants, including 9,849 new and competing awards.

HHS BUDGET BY OPERATING DIVISON

(mandatory and discretionary dollars in millions)

	2008	2009	2010 1/	2010 +/-2009
Food & Drug Administration:				
Program Level	2,420	2,668	3,178	511
Budget Authority	1,873	2,058	2,353	295
Outlays	1,150	2,045	2,218	173
Health Resources & Services Administration:				
Budget Authority (excl. Recovery Act)	6,943	7,352	7,250	-102
Recovery Act Budget Authority	-	2,500	-	-
Outlays	7,044	6,915	8,535	1,620
Indian Health Service:				
Budget Authority (excl. Recovery Act)	3,497	3,731	4,185	454
Recovery Act Budget Authority	-	500	-	-
Outlays	3,248	3,984	4,297	313
Centers for Disease Control & Prevention:				
Budget Authority (excl. Recovery Act)	6,181	6,414	6,446	32
Recovery Act Budget Authority	-	300	-	-
Outlays	5,880	6,322	6,699	377
National Institutes of Health:				
Budget Authority (excl. Recovery Act)	29,607	30,545	30,988	443
Recovery Act Budget Authority	-	10,400	-	-
Outlays	29,123	32,921	35,394	2,473
Substance Abuse & Mental Health Services:				
Budget Authority	3,234	3,335	3,394	59
Outlays	3,129	3,377	3,343	-34
Agency for Healthcare Research & Quality:				
Program Level	335	372	372	-
Budget Authority (excl. Recovery Act)	-	3		-3
Recovery Act Budget Authority 2/	-	700	-	-
Outlays	-101	66	235	169
Centers for Medicare & Medicaid Services:				
Budget Authority (excl. Recovery Act)	619,102	669,085	720,405	51,320
Recovery Act Budget Authority	-	35,932	43,083	-
Outlays	597,705	700,847	756,700	55,853
Administration for Children & Families:				
Budget Authority (excl. Recovery Act)	48,220	51,455	48,962	-2,493
Recovery Act Budget Authority 3/	-	10,930	1,268	-
Outlays	48,469	56,052	56,053	1
Administration on Aging:				
Budget Authority (excl. Recovery Act)	1,411	1,488	1,491	3
Recovery Act Budget Authority	-	100	-	-
Outlays	1,398	1,505	1,520	15
Office of the National Coordinator:				
Budget Authority (excl. Recovery Act)	42	24	42	18
Recovery Act Budget Authority	-	2,000	-	-
Outlays	57	212	1,229	1,017

1/ FY 2009 Recovery Act appropriations were provided to fund programmatic costs in multiple fiscal years.

2/ The Recovery Act appropriated $1.1 billion for comparative effectivness research and transferred $400 million of this amount to NIH. Of the remaining $700 million, $400 million is for allocation at the discretion of the Secretary.

3/ Recovery Act contains $5,150 million in discretionary budget authority and $5,000 million in mandatory budget authority.

HHS BUDGET BY OPERATING DIVISION

(mandatory and discretionary dollars in millions)

	2008	2009	2010 1/	2010 +/-2009
Medicare Hearings and Appeals:				
Budget Authority	64	65	71	6
Outlays	81	65	71	6
Office for Civil Rights				
Budget Authority	35	41	42	1
Outlays	36	41	42	1
Departmental Management:				
Budget Authority (excl. Recovery Act)	356	406	419	13
Recovery Act Budget Authority	-	5	-	-
Outlays	415	353	409	56
Prevention and Wellness				
Recovery Act Budget Authority		700		
Outlays		154	420	266
Public Health Social Service Emergency Fund:				
Budget Authority (excl. Recovery Act)	729	1,398	2,678	1,280
Recovery Act Budget Authority	-	50	-	-
Outlays	1,858	1,993	2,405	412
Office of Inspector General:				
Budget Authority (excl. Recovery Act)	68	95	75	-20
Recovery Act Budget Authority	-	48	-	-
Outlays	40	117	112	-5
Program Support Center (Retirement Pay, Medical Benefits, Misc. Trust Funds):				
Budget Authority	520	552	593	41
Outlays	558	581	616	35
Offsetting Collections:				
Budget Authority	-1,243	-1,352	-1,102	250
Outlays	-1,243	-1,352	-1,102	250
Total, Health & Human Services:				
Budget Authority (excl. Recovery Act)	**720,639**	**776,695**	**828,292**	**+51,597**
Total Recovery Act Budget Authority		**64,165**	**44,351**	**-19,814**
Total Budget Authority	**720,639**	**840,860**	**872,643**	**+31,783**
Outlays	**698,847**	**816,198**	**879,196**	**+62,998**
Full-Time Equivalents	64,509	67,403	69,919	+2,516

COMPOSITION OF THE HHS BUDGET

(dollars in millions)

	2008	2009 ARRA 1/	2009 Omnibus	2010	2010 +/-2009 Omnibus
Discretionary Programs (Budget Authority)					
Food & Drug Administration	1,870	--	2,055	2,350	+295
FDA Program Level	*2,420*	--	*2,668*	*3,178*	+511
Health Resources & Services Administration	6,864	2,500	7,243	7,141	-102
HRSA Program Level	*6,923*	*2,500*	*7,296*	*7,190*	-107
Indian Health Service	3,346	500	3,581	4,035	+454
IHS Program Level	*4,297*	*500*	*4,536*	*4,989*	+454
Centers for Disease Control & Prevention	6,124	300	6,357	6,389	+32
CDC Program Level	*9,227*	*300*	*10,124*	*10,102*	-22
National Institutes of Health	29,457	10,400	30,395	30,838	+443
NIH Program Level	*29,615*	*10,400*	*30,553*	*30,996*	+443
Substance Abuse & Mental Health Services	3,234	--	3,335	3,394	+59
SAMHSA Program Level	*3,356*	--	*3,466*	*3,525*	+59
Agency for Healthcare Research & Quality	--	*700*	--	--	--
AHRQ Program Level	*335*	700	*372*	*372*	--
Centers for Medicare & Medicaid Services	3,152	--	3,230	3,466	+235
CMS Program Level (Excluding HCFAC)	*3,858*	--	*3,701*	*3,940*	+238
Administration for Children & Families Services	14,322	5,150	17,225	15,591	-1,634
ACF Program Level	*14,382*	*5,150*	*17,273*	*15,651*	-1,622
Administration on Aging	1,413	100	1,491	1,491	--
AoA Program Level	*1,417*	*100*	*1,512*	*1,495*	-18
Departmental Management	355	--	396	410	+14
OS Program Level	*407*	--	*448*	*475*	+27
Office for Civil Rights	34	--	40	41	+1
Office of the National Coordinator	42	2,000	44	42	-1
ONC Program Level	*61*	*2,000*	*61*	*61*	--
Medicare Hearings and Appeals	64	--	65	71	+6
Office of Inspector General	43	17	45	50	+6
OIG Program Level	*248*	*17*	*301*	*292*	-8
Health Care Fraud and Abuse Control (Discretionary)	--	--	198	311	+113
HCFAC Program Level	*1,157*	--	*1,384*	*1,509*	+125
Public Health & Social Services Emergency Fund	729	50	1,398	1,415	+17
PHSSEF Program Level	*729*	*50*	*1,398*	*1,415*	+17
Prevention and Wellness (OS)	--	700	--	--	--
Medicare Eligible Healthcare Accruals (Com. Corps)	37	--	35	36	+1
HPSL/NSL/LDS/PCL Rescission	-15	--	--	--	--
Aligning Head Start to Budget Year	--	--	1,389	--	-1,389
Recisions of Prior Year Balances	--	--	-22	--	+22
BioShield Transfer	--	--	--	1,264	+1,264
Offset for PHS Evaluation Funds (Prog. Level)	*-892*	--	*-943*	*-957*	*-14*
HCFAC Funds in Agency Prog. Levels or DOJ 2/	*-388*	*-456*		*-452*	*3*
Total, Discretionary Budget Authority	**71,072**	**22,417**	**78,500**	**78,334**	**-166**
Subtotal, Discretionary Program Level	***77,272***	***22,417***	***85,203***	***85,192***	***-11***
Discretionary Outlays	**70,647**	--	**82,037**	**89,289**	**+7,252**

1/ American Recovery and Reinvestment Act of 2009 (ARRA)

2/ In addition to HCFAC amounts in Agency program levels, $25 million is shown in OIG for Medicaid Integrity (FY 2008, 2009, and 2010); $25 million in OIG for Medicaid Fraud in FY 2009; and the following amounts transferred to the Department of Justice (DOJ): $175 million in FY 2008, $201 million in FY 2009, $211 million in FY 2010.

COMPOSITION OF THE HHS BUDGET

(dollars in millions)

	2008	2009	2010	2010 +/-2009
Mandatory Programs (Outlays) 1/:				
Medicare 2/	385,782	425,423	452,370	+26,947
Medicaid 2/	201,426	262,389	289,763	+27,374
Temporary Assistance for Needy Families 3/	17,880	20,283	19,447	-836
Foster Care & Adoption Assistance	6,750	7,079	7,198	+119
Children's Health Insurance Program	6,900	8,566	10,095	+1,529
Child Support Enforcement	4,283	4,472	4,588	+116
Child Care	2,909	2,927	2,938	+11
Social Services Block Grant	1,843	1,909	2,009	+100
Other Mandatory Programs	1,626	2,437	2,601	+164
Offsetting Collections	-1,199	-1,324	-1,102	+222
Subtotal, Mandatory Outlays	628,200	734,161	789,907	+55,746
Total, HHS Outlays	**698,847**	**816,198**	**879,196**	**+62,998**

1/ FY 2009 and FY 2010 Recovery Act funding included in this table. See details on Mandatory Recovery Act table.

2/ FY 2010 does not include Medicaid savings of $1.450 billion and Medicare savings of $520 million to finance health care reform.

3/ Includes outlays for the Child Enrollment Contingency Fund in FY 2009 and FY 2010.

HEALTH REFORM

The Administration is committed to reforming the health care system to assure affordable, quality health coverage for all Americans.

THE NEED FOR HEALTH REFORM

One of the biggest drains on American family budgets and the performance of the economy is the high cost of health care. Health insurance premiums have nearly doubled since 2000, rising four times faster than wage growth. This strains both families and the businesses that struggle to sustain health benefits. At the same time, health care costs are consuming a growing share of Federal and State government budgets.

The United States spends over $2.2 trillion on health care each year, a number that represents about 16 percent of the total economy and is growing rapidly. By 2017, almost 20 percent of the economy—more than $4 trillion—will be spent on health care. While the United States leads the world in health expenditures by a wide margin, our health outcomes often fall short of those achieved by other developed countries.

Across our Nation, health care costs vary substantially, yet the higher-cost areas do not generate better health outcomes than the lower-cost areas. Some researchers believe that health care costs could be reduced by 30 percent—or about $700 billion a year—without harming quality if we moved as a Nation toward the proven and successful practices adopted by the lower-cost areas and hospitals.

At the same time that we strive to control the growth of health care costs, more than 45 million Americans lack health care coverage. An unhealthy workforce leads to an unhealthy economy, and providing all Americans with health insurance is not only a moral imperative, but it is also essential to a more effective and efficient health care system.

DOWN PAYMENT ON HEALTH REFORM

Major strides have already been made in the Recovery Act and the Children's Health Insurance Program (CHIP) reauthorization:

- *CHIP*: Covering millions more uninsured children;
- *COBRA*: Temporarily lowering the cost of COBRA coverage by 65% for workers and their families;
- *Health IT*: Embarking on an effort to computerize health records in five years;
- *Comparative Effectiveness*: Devoting $1.1 billion to comparative effectiveness research; and
- *Prevention*: Investing $1 billion in prevention and wellness.

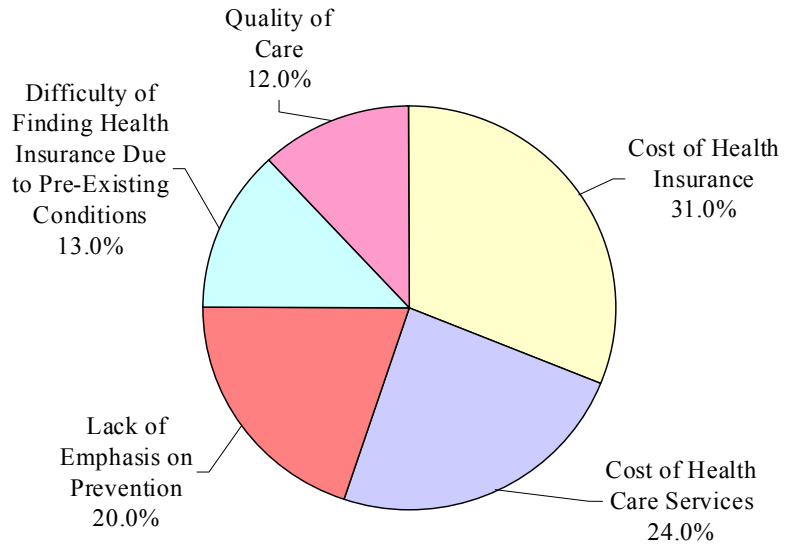
AN OPEN AND INCLUSIVE PROCESS

The Administration is committed to an open and inclusive process for health reform, giving all Americans and stakeholders a voice in the outcome.

Community Discussions: In December 2008, the Presidential Transition Team invited Americans to host and participate in Health Care Community Discussions to talk about how to reform health care in America. HHS released a report detailing the concerns and suggestions reported from more than 3,000 meetings with more than 30,000 participants. Participants saw cost as the largest problem with the current system, and identified fairness as a key value that the system should support.

White House Forum: On March 5th, the President hosted the White House Forum on Health Care Reform, bringing together members of Congress and key stakeholders

Top Concerns of Health Care Community Discussion Participants



Source: Americans Speak on Health Reform: Report on Health Care Community Discussions, March 2009

from throughout the health care system to discuss ideas on how to drive down health care costs and improve coverage. That event has been followed by a series of Regional White House Forums on Health Reform bringing the conversation about how to reform our health care system directly to communities across the country.

Eight Principles For Health Reform

In working with the Congress to pass health reform legislation, the Administration has set out the following principles for the resulting plan:

Reduce Long-term Growth of Health Care Costs for Businesses and Government: The plan must pay for itself by reducing the level of cost growth, improving productivity, and dedicating additional sources of revenue.

Protect Families from Bankruptcy or Debt Because of Health Care Costs: The plan must safeguard American families' financial health, protecting people from bankruptcy due to catastrophic illness.

Guarantee Choice of Doctors and Health Plans: The plan should provide Americans a choice of health plans and physicians. They should have the option of keeping their employer-based health plan.

Invest in Prevention and Wellness: The plan must invest in public health measures proven to reduce costs in our system, as well as guarantee access to proven preventive services.

Improve Patient Safety and Quality Care: The plan must use proven patient safety measures and provide incentives for quality care delivery. It must support the widespread use of health information technology and the development of data on the effectiveness of medical interventions to improve the quality of care delivered.

Assure Affordable, Quality Health Coverage for All Americans: The plan must put the United States on a clear path to cover all Americans. The plan must reduce high administrative costs, unnecessary tests and services, waste, and other inefficiencies that consume money with no added health benefits.

Maintain Coverage When You Change or Lose Your Job: People should not face the loss of health coverage when they lose or change their job.

End Barriers to Coverage for People with Pre-existing Medical Conditions: No American should be denied coverage because of pre-existing conditions.

Financing Health Reform

The Budget establishes a Health Reform Reserve Fund of about $600 billion over 10 years to finance fundamental reform of our health system to bring down costs and expand coverage. The Administration recognizes that while the reserve fund is a significant commitment, it is not sufficient to fully fund comprehensive reform, and we look forward to working with Congress to identify additional resources. The reserve is funded by new revenue and by savings from Medicare and Medicaid. The goals behind these savings proposals are described below, with additional details described in the Medicare and Medicaid sections of this book.

Aligning Incentives Toward Quality: Proposals in the Budget that improve incentives to provide high quality care in Medicare include quality incentive payments to hospitals and voluntary physician groups, and reduced payments to hospitals with high readmission rates.

Promoting Efficiency and Accountability: The Budget includes savings from increasing the efficiency and accountability of Medicare and Medicaid. Proposals include reducing Medicare payments to private insurers through competition, implementing policies to decrease Medicaid costs for prescription drugs, improving Medicare and Medicaid payment accuracy, and bundling Medicare payments for inpatient hospital and post-acute care.

Encouraging Shared Responsibility: Moving toward a reformed health system will require all stakeholders to contribute a fair share. The Budget includes a proposal to require certain higher-income Medicare beneficiaries enrolled in Part D to pay higher premiums, as is currently required for physician and outpatient services.

New Revenues: Comprehensive health reform will require new revenues. Among other changes, the Budget includes a proposal to limit the rate at which high-income taxpayers can take itemized deductions, with the revenues dedicated to health reform.

RECOVERY ACT

The American Recovery and Reinvestment Act was signed into law by President Obama on February 17, 2009. The Recovery Act provides funding for Health IT, Comparative Effectiveness Research, Prevention and Wellness, Scientific Research, Social Services and Medicaid relief to the States.

The American Recovery and Reinvestment Act (Recovery Act) includes an estimated $167 billion over ten years for programs at HHS.

The Recovery Act will increase HHS mandatory Budget Authority by an estimated $144 billion, with most of the increase in FY 2009 and FY 2010, and predominantly directed to Medicaid.

HHS also received $22 billion in discretionary budget authority. The majority of these funds will be obligated by September 2010 to achieve the most rapid impact for citizens and States affected by the current economic downturn.

HHS Recovery Act activities support efforts to increase access to health care, protect those in greatest need, expand educational opportunities, and modernize the Nation's infrastructure. HHS is committed to quickly and carefully distributing Recovery Act funds in an open and transparent manner that will achieve the objectives of the Recovery Act. HHS quickly established new policy and technical processes to review spending plans and to implement the Recovery Act requirements for transparency and accountability. To coordinate and manage the complexity of HHS' role and processes in the Recovery Act, HHS established an Office of Recovery Act Coordination. This Office will ensure that HHS fully implements the Act's requirements and OMB's guidance including meeting reporting due dates, establishing and tracking performance outcomes, mitigating risks of fraud and abuse, and keeping the public informed through the web and other means of communication.

HHS Recovery Act activities touch the lives of Americans and pave the way for health care reform by:

- Improving and Preserving Health Care;
- Accelerating the Adoption of Health IT;
- Strengthening Scientific Research and Facilities;
- Improving Children and Community Services;
- Strengthening Community Health Care Services;
- Supporting Comparative Effectiveness:
- Promoting Prevention and Wellness; and
- Improving Accountability and IT Security.

MAKING AN IMMEDIATE IMPACT

HHS released over $16 billion in Recovery Act funds within the first 30 days of enactment, including crucial fiscal relief to States through increased Medicaid funding, funds for Community Health Centers, and funds for Foster Care and Adoption Assistance. Overall, HHS will distribute more than 90 percent of its increased discretionary funding, and approximately two-thirds of its increased mandatory spending, within two years of enactment.

IMPROVING AND PRESERVING HEALTH CARE

FMAP Increase: The Recovery Act temporarily increases the Medicaid Federal share of expenditures by an estimated $87 billion through a 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP) for all States, with additional relief tied to rates of unemployment. Territories also benefit from increased Medicaid funding.

Temporary Increase in DSH Allotments: The Recovery Act provides an estimated $770 million in increased State Disproportionate Share Hospital (DSH) payments through a 2.5 percent increase in FY 2009 and FY 2010 allotments. These payments assist hospitals that serve a disproportionate share of low-income or uninsured patients.

Transitional Medical Assistance: The Recovery Act provides an estimated $915 million in additional Medicaid expenditures by extending Transitional Medical Assistance (TMA) through December 31, 2010, including provisions to allow States to provide assistance for longer periods and to waive some requirements for families seeking assistance.

Qualified Individuals Program: The Recovery Act provides an estimated $563 million to extend premium assistance for Medicare beneficiaries who are Qualified Individuals (incomes of 120-135 percent of the poverty line) through December 31, 2010.

Health Professions: The Recovery Act provides $200 million to a range of programs that can address critical shortages in primary care, nursing, and public health.

Medicaid and CHIP Provisions to Benefit American Indians and Alaska Natives: The Recovery Act provides protections for Indians

under the Medicaid and CHIP programs, including requirements for managed care organizations, limits on cost-sharing, and exclusion of certain property for purposes of determining eligibility for Medicaid and CHIP.

Accelerating the Adoption of Health IT

The Recovery Act includes both additional resources and a new authorization to guide the Federal government's Health Information Technology (IT) activities. Medicare and Medicaid estimates for Health IT reflect revised actuarial estimates of the enacted legislation.

Incentives for Electronic Health Records: The Recovery Act provides an estimated $44.7 billion in incentives through Medicare and Medicaid to encourage physicians and hospitals to adopt certified electronic health record (EHR) technology.

Medicare Incentives ($23.1 billion): For each qualified physician, incentive payments to encourage EHR adoption would be a maximum of $18,000 in 2011, decreasing to zero by 2015. Physicians not adopting EHRs will see their fee schedule payments reduced by 1 percent in 2015, growing to 3 percent in 2017 and between 3 to 5 percent thereafter. For hospitals, incentive payments will vary based on Medicare inpatient days, hospital discharges, and charity care. Hospitals not adopting EHR by 2014 will receive a reduced market basket update beginning in 2015.

Medicaid Incentives ($21.6 billion): The Recovery Act also provides 100 percent Federal match for State expenditures for incentive payments to eligible Medicaid providers for certified EHR technology and 90 percent Federal match for related State and administrative expenses. Physician payments are subject to provider dollar limits and hospital payments are based on a formula prescribed in statute and are available over a six-year period.

Office of the National Coordinator for Health IT: The Recovery Act authorizes Federal Health IT efforts through the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and provides $2 billion for those efforts. These activities include the creation of a Health IT Standards + Policy Committees, support for regional or sub-regional efforts towards a health information exchange, and funding for the National Institute of Standards and Technology.

The HITECH Act also enhances privacy protections by expanding the Health Insurance Portability and Accountability Act (HIPAA) to include Medicare Part D, applying HIPAA security standards and privacy rules to business associates, and increasing enforcement and penalties for violations.

Strengthening Scientific Research and Facilities

NIH: The Recovery Act provides a total of $10 billion to NIH, including $8.2 billion for general biomedical research, of which $800 million will be distributed by the Office of the Director for specific trans-NIH challenges and priority projects; $1.3 billion for extramural research infrastructure, including laboratories and shared equipment; and $500 million for intramural facility construction, repairs, and renovations. In addition, $400 million will be transferred to NIH for comparative effectiveness research, as described below.

Improving Children and Community Services

Child Support Enforcement: The Recovery Act provides an estimated $1 billion to the States through FY 2010, to match Federal incentive payments that are reinvested into State programs. The funding will improve and strengthen child support enforcement efforts, which generally become more difficult in times of economic hardship.

Foster Care and Permanency: The Recovery Act provides an estimated $806 million through a 6.2 percentage point FMAP increase through December 2010 for maintenance payments to the States and Puerto Rico for foster care, adoption, and kinship guardianship assistance programs.

Temporary Assistance for Needy Families (TANF): The Recovery Act provides $5 billion to States, Territories, and Tribes through a new Emergency Contingency Fund to assist low-income families during the economic downturn.

States can request Emergency Funds if they have increased TANF caseloads and related basic assistance spending; increased spending on non-recurrent short-term benefits; or increased spending on subsidized employment.

The Recovery Act also includes $319 million to extend TANF Supplemental grants through FY 2010. These grants provide additional assistance to 17 States with historically high population growth or increased poverty.

Child Care and Development Block Grant (CCDBG): The Recovery Act provides $2 billion for supplementing State funds for child care assistance to low-income families. A portion of the funds are also reserved for quality improvement activities.

Head Start and Early Head Start: The Recovery Act provides $2.1 billion for Head Start, including $1.1 billion for Early Head Start. This significant increase expands Head Start and Early Head Start services to approximately 70,000 additional children, 55,000 of whom are infants and toddlers. Additionally, the Recovery Act enabled all grantees to receive their full cost of living increase for FY 2009.

Community Services Block Grant (CSBG): The Recovery Act provides $1 billion to States to distribute to community action agencies to reduce poverty and assist low-income residents in becoming self-sufficient. Eligible entities can serve individuals with incomes up to 200 percent of the poverty line – an increase above the previous limit of 125 percent of the poverty line.

Strengthening Communities Fund: The Recovery Act provides $50 million to build the capacity of nonprofits, including faith and community-based organizations, and government entities to address the needs of low-income and disadvantaged populations.

Nutrition Programs for Seniors: The Recovery Act includes $100 million for nutrition programs for seniors. The funds will bolster assistance provided through Congregate Nutrition Services, Home-Delivered Nutrition Services, and Native American Nutrition Services.

Strengthening Community Health Care Services

HRSA Health Centers and National Health Service Corps: The Recovery Act provides $1.5 billion to modernize, renovate and repair health centers. These funds will also be used for the acquisition of health IT systems. An additional $500 million is provided to support new health center sites and service areas, increase services at existing sites, and provide supplemental payments for spikes in uninsured populations.

The Recovery Act also provides $300 million to increase the ranks of National Health Service Corps by placing clinicians in health professional shortage areas.

IHS Facilities: The Recovery Act provides $415 million for building maintenance and repair, the construction of priority health care facilities and water sanitation projects, and the purchase of medical equipment. In addition, $85 million is provided for health IT activities including telehealth and infrastructure developments.

Supporting Comparative Effectiveness

The Recovery Act provides $1.1 billion in total for comparative effectiveness research, including $300 million for AHRQ, $400 million for NIH, and $400 million allocated through the Office of the Secretary. The Recovery Act also establishes a Federal Coordinating Council for Comparative Effectiveness Research to reduce duplication of these activities within the government. The Council and a mandated report from the Institute of Medicine will guide the Secretary in allocating this funding.

Promoting Prevention and Wellness

A total of $1 billion is provided through the Recovery Act for the prevention and wellness activities. Of this amount, $300 million is for the CDC Section 317 Immunization Program and $50 million is to be provided to States to implement health care-associated infections reduction strategies. The remaining $650 million is for evidence-based clinical and community-based prevention and wellness strategies that address chronic disease rates.

Improving Accountability and IT Security

IT Security: The Recovery Act provides $50 million to improve the security of the HHS IT infrastructure. The Recovery Act funding will support agency-wide investments and accelerate efforts by HHS to improve security architecture. Funds will also support security tools to protect sensitive information and strengthen computer defense mechanisms against attacks.

Accountability: The Recovery Act provides $48 million for the Office of Inspector General to enhance accountability and enforcement activities to prevent waste, fraud and abuse.

RECOVERY ACT

(dollars in millions)

Appropriations are two-year budget authority funds unless otherwise noted.

Discretionary Programs (Budget Authority)	2009
Health Resources and Services Administration	
Community Health Centers	*2,000*
Health Centers Modernization, Renovation, and Repair	1,500
Health Care Services	500
Health Professions	*500*
	2,500
Indian Health Service	
Buildings and Facilities	*415*
Health IT	*85*
	500
Centers for Disease Control and Prevention	
Section 317 Immunization Program	*300*
	300
National Institutes of Health	
Scientific Research	*8,200*
Extramural Lab Construction and Renovation	*1,000*
Buildings and Facilities	*500*
Shared instrumentation grants/contracts	*300*
Comparative Effectiveness (Transfer from AHRQ)	*400*
	10,400
Administration for Children and Families	
Child Care and Development Block Grant (CCDBG)	*2,000*
Early Head Start	*1,100*
Head Start	*1,000*
Community Services Block Grant (CSBG)	*1,000*
Strengthening Communities Fund	*50*
	5,150
Administration on Aging	
Congregate Nutrition Services and Home-Delivered Nutrition Services	*65*
Home-Delivered Nutrition Services	*32*
Native American Nutrition Services	*3*
	100
Office of the Inspector General	
Oversight and Audits of Programs, Grants and Projects	**17**
HHS Information Technology Security (PHSSEF)	**50**
Health Information Technology (ONC)	**2,000**
Prevention and Wellness (CDC, CMS, OS) 1/	
Evidence-based Clinical and Community-based Prevention Strategies	*650*
Healthcare Associated Infection Reduction Strategies in States (CDC, CMS)	*50*
	700
Comparative Effectiveness (AHRQ) 2/	
AHRQ	*300*
Department-wide	*400*
	700
Total HHS Discretionary	**22,417**

1/ The Recovery Act includes $1,000 million for Prevention and Wellness; $300 million is statutorily transferred to CDC.

2/ The Recovery Act includes $1,100 million for Comparative Effectiveness; $400 million is statutorily transferred to NIH.

RECOVERY ACT

(dollars in millions)

	2009	2010	2009-2019
Mandatory Programs			
Centers for Medicare & Medicaid Services (CMS)			
Medicare			
HIT Incentive Payments to Providers	--	--	23,100
Moratorium on Medicare Regulations (Hospice, IME Reduction)	300	*	200
Subtotal, Medicare	**300**	--	**23,300**
Medicaid			
HIT Incentive Payments to Providers	--	--	21,640
State Administrative Costs for HIT Implementation	--	30	1,055
Subtotal, Medicaid HIT (non-add)	--	*30*	*22,695*
Temporary Increase in Medicaid FMAP	35,200	41,400	87,450
Temporary Increase in Disproportionate Share Hospital (DSH) Allotments	250	520	770
Transitional Medical Assistance (TMA) Extension	30	480	915
Qualified Individuals (QI) Extension	--	413	563
Protections for Indians Under Medicaid and CHIP	5	10	150
Interaction of Section 5001 with Other Medicaid Provisions	5	90	115
Subtotal, Medicaid	**35,490**	**42,943**	**112,658**
Total HIT Incentive Payments to Providers, Medicare and Medicaid (non-add)	--	--	*44,740*
Adminstration for Children and Families (ACF)			
TANF			
Emergency Fund	5,000	--	5,000
Supplemental Grants	--	319	319
Subtotal, TANF	**5,000**	**319**	**5,319**
Child Support Enforcement	**426**	**590**	**1,016**
FMAP Foster Care/Adoption Assistance	**354**	**359**	**806**
Total Program	**41,570**	**44,211**	**143,099**
Mandatory Administration			
CMS Program Management			
Medicare HIT Implementation	100	100	745
Medicaid HIT Implementation	40	40	300
Medicare Moratoria	2	--	2
Subtotal, CMS Program Management	**142**	**140**	**1,047**
Departmental Management			
Medicaid FMAP Implementation	5	--	5
OIG Medicaid Oversight	31	--	31
Subtotal, General Departmental Management	**36**	**--**	**36**
Total Administration	**178**	**140**	**1,083**
Total HHS Recovery Act Mandatory Budget Authority	**41,748**	**44,351**	**144,182**
Total HHS Recovery Act Discretionary Budget Authority	**22,417**	**--**	**22,417**
Total HHS Recovery Act Budget Authority	**64,165**	**44,351**	**166,599**
Memorandum:			
Total HHS Recovery Act Mandatory Outlays/1	37,189	45,502	141,771

/1 Equals Budget Authority (BA) in all cases other than TANF where the estimate was $2.4 billion less than BA over 2009-2019. Unobligated balances for the TANF Emergency Contingency Fund are carried forward through FY 2010.

*Indicates negligible savings.

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(dollars in millions)

	2008	2009	2010	2010 +/- 2009
Program				
Foods	577	649	846	+197
Human Drugs	708	777	908	+131
Biologics	249	271	306	+34
Animal Drugs and Feeds	115	134	171	+37
Medical Devices	304	330	371	+42
National Center for Toxicological Research	47	53	59	+6
Headquarters and Office of the Commissioner	146	160	205	+45
FDA Consolidation at White Oak	39	41	41	--
GSA Rental Payments	159	155	173	+18
Other Rent and Rent Related Activities	61	70	75	+5
Export/Color Certification Fund	10	10	10	--
Subtotal, Salaries and Expenses	2,414	2,652	3,166	+514
Buildings and Facilities	6	12	12	--
National Center for Natural Products Research	4	3	--	-3
Total, Program Level	**2,420**	**2,668**	**3,178**	**+511**
Less User Fees:				
Current Law				
Prescription Drug (PDUFA)	459	511	578	+67
Medical Device (MDUFMA)	48	53	57	+4
Animal Drug (ADUFA)	14	15	17	+2
Animal Generic Drug	--	5	5	--
Mammography Quality Standards Act (MQSA)	18	19	19	--
Export/Color Certification Fund	10	10	10	--
Subtotal, Current Law User Fees	549	613	687	+74
Proposed Law				
Food Inspection and Food Facility Registration	--	--	75	+75
Human Generic Drug	--	--	36	+36
Reinspection	--	--	26	+26
Export Certification Fund (Foods and Feeds)	--	--	4	+4
Subtotal, Proposed Law User Fees	--	--	141	141
Total, User Fees	**549**	**613**	**828**	**+215**
Total, Budget Authority	**1,870**	**2,055**	**2,350**	**+295**
Biodefense (non-add):				
Food Defense	171	213	217	+4
Vaccines/Drugs/Diagnostics	56	67	68	+1
Physical Security	7	7	7	--
Subtotal, Biodefense (non-add)	234	287	292	+6
FTE	10,299	10,953	12,130	+1,177

FOOD AND DRUG ADMINISTRATION

The FDA is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. The FDA is also responsible for advancing the public health by helping to speed innovations that make medicines and foods more effective, safer, and more affordable; and helping the public get the accurate, science-based information they need to use medicines and foods to improve their health.

The FY 2010 Budget requests over $3.2 billion for the Food and Drug Administration (FDA), a net program level increase of $511 million over FY 2009. This is the largest increase ever requested for FDA. The FDA budget includes increased investments to improve the safety of the Nation's food supply, drugs, and other medical products, accelerate the availability of new and innovative medical products and provide Americans access to more affordable drugs.

ENHANCING THE SAFETY OF THE NATION'S FOOD SUPPLY

The FDA plays a critical role in helping to ensure that the food we eat is safe and does not cause harm. Because of this, the United States has one of the safest food supply chains in the world. In recent years, there have been a number of problems with the food that has made its way to our kitchen tables, including outbreaks of salmonella caused by contaminated peppers and peanut butter products. These recent problems underscore the challenges the Nation faces in food safety.

The Administration recognizes these challenges and is working with State, local, and international food safety partners, and with industry and consumers to increase focus on prevention and improve oversight and enforcement. The FY 2010 President's Budget includes over $1 billion for food safety, a $259 million increase over the FY 2009 level, including $75 million in new user fees for food inspection and food facility registration and $19 million for reinspection and export certification. This user fee will provide funding for increased inspections and help to defray costs related to ensuring compliance by food facility establishments. With these increased resources, FDA will be able to expand on investments in strategic prevention, intervention and response to reduce unintentional and intentional contamination of FDA-regulated food in foreign and domestic commerce at all points in the supply chain. FDA will expand its overseas presence, import review and analysis, laboratory analysis and output capacity, and upgrade IT systems to achieve a modern bioinformatics and information management platform. FDA will expand domestic surveillance activities, and strengthen its ability to support State food safety inspections. FDA will increase the number of food inspectors by approximately 20 percent in FY 2010.

IMPROVING THE SAFETY AND REVIEW OF MEDICAL PRODUCTS

FDA is a leading regulatory agency for review of medical products in the world. Because of FDA, Americans have access to thousands of drugs and devices that are safe and effective for their intended uses, treating everything from seasonal allergies to advanced cancer. The FY 2010 President's Budget includes an increase of $166 million above FY 2009 to enhance the safety oversight of medical products. The increases will support a life-cycle approach to safety, which starts at product development and pre-approval testing, through approval, and post-approval safety surveillance. The additional funding also provides for increased inspections to improve the security of the supply chain, and supports implementation of requirements included in the FDA Amendments Act.

The Administration is committed to promoting the development of new products to treat life-threatening conditions, and lowering the cost of drugs for all Americans. In total, the FY 2010 Budget request will provide an investment of over $1.2 billion for medical product safety.

LOWERING THE COST OF DRUGS FOR AMERICANS

Prescription drug costs are high and rising, causing many Americans to split pills, skip doses or not take

Providing Access to More Affordable Drugs

FDA is committed to protecting the safety of the American public while promoting innovation and providing access to more affordable medicines.

- Creating a safe regulatory pathway for generic biologics will allow greater access to life-saving drugs at an affordable price.
- The reimportation of safe medicines will aid in lowering drug costs.
- An industry funded user fee for generic drug review will expedite review, allowing FDA to approve more generic drugs each year.

needed medication altogether. The FY 2010 Budget request includes three proposals to lower the cost of drugs for all Americans.

Generic Biologics: The Administration will accelerate access to make affordable generic biologic drugs available through the establishment of a workable regulatory, scientific, and legal pathway for generic versions of biologic drugs. In order to retain incentives for research and development for the innovation of breakthrough products, a period of exclusivity would be guaranteed for the original innovator product, which is generally consistent with the principles in the Hatch-Waxman law for traditional products. Additionally, brand biologic manufacturers would be prohibited from reformulating existing products into new products to restart the exclusivity process, a process known as "ever-greening."

Drug Importation: The FY 2010 President's Budget includes a proposal to allow Americans to buy safe and effective drugs from other countries. The Budget request includes $5 million to allow FDA to begin working with the various stakeholders to develop policy options related to drug importation. In addition, the Administration will work with Congress to enact authorizing legislation to support the infrastructure required to ensure the safety of these medicines.

Generic Drug Review: Increasing access to safe and affordable generic drugs is a priority at the FDA. The FY 2010 President's Budget proposes $36 million for a new industry-funded generic drug user fee, which will aid in lowering drug costs by bringing more generics to market. These additional resources will help to make drugs safer, more affordable and more readily available.

IMPROVING SAFETY AND COMPLIANCE THROUGH USER FEES

In addition to the proposed generic drug user fee and the food inspection and food facility registration user fee, which are mentioned above, the FY 2010 Budget request proposes the Reinspection User Fee and the Export Certification User Fee for food and animal feeds. The proposed Reinspection User Fee of $26 million requires manufacturers and laboratories to pay the full costs of reinspections and associated follow-up work due to their failure to meet FDA requirements during an inspection. This proposal rewards firms for complying with health and safety standards while ensuring that companies are charged the costs of reinspection when they fail to meet FDA safety and quality regulations.

The second user fee, export certification for food and animal feeds, proposes to expand the current drug, animal drug, and medical device export certification user fee program by $4 million to also include food and animal feed. Export certificates issued by FDA enhance the global competitiveness of American food and animal feed producers by ensuring that the products meet regulatory requirements. With this expansion, the food and animal feed industry will no longer receive preferential treatment through government funding of export certificates.

SUPPORTING FDA FACILITIES

The FY 2010 Budget requests $39 million in budget authority for headquarters consolidation at the new FDA campus in White Oak, Maryland. These resources will enable FDA to continue to transition to the newly consolidated facility under construction by the General Services Administration (GSA). At White Oak, FDA operates in modern laboratories and facilities equipped with the latest technologies and tools that allow FDA scientists and health professionals to execute their mission-critical responsibilities. The White Oak Campus replaces existing fragmented facilities with state-of-the-art laboratories and program support facilities.

The Budget also requests an increase of $14 million for GSA rental payments and other rent and rent-related costs. In FY 2010, the budget provides $12 million to pay for necessary repair and maintenance of FDA-owned facilities nationwide.

Performance Highlight

FDA is continuing to develop a more quantitative risk model to help predict where FDA's inspections are most likely to achieve the greatest public health impact. The Risk-Based Site Selection Model provides a risk score for each facility, which is a function of four component risk factors- Product, Process, Facility, and Knowledge. As enhancements are made to FDA's data collection efforts and to the Risk-Based Site Selection Model, FDA will improve its ability to focus inspections on the highest-risk public health concerns in a cost effective way.

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(dollars in millions)

	2008	2009 ARRA*	2009 Omnibus	2010	2010 +/- 2009 Omnibus
Primary Care					
Health Centers:					
Health Centers	2,022	2,000	2,146	2,146	--
Health Centers Tort Claims	43	--	44	44	--
Subtotal, Health Centers	2,065	2,000	2,190	2,190	--
Free Clinics Medical Malpractice	.04	--	.04	.04	--
Hansen's Disease Programs	18	--	18	18	--
Subtotal, Primary Care	2,083	2,000	2,208	2,208	--
Clinician Recruitment and Service					
National Health Service Corps:					
National Health Service Corps Field	40	60	40	46	+7
National Health Service Corps Recruitment	84	240	95	123	+27
Subtotal, National Health Service Corps	123	300	135	169	+34
Nurse Loan Repayment & Scholarship Program	31	TBD	37	125	+88
Loan Repayment / Faculty Fellowships	1	TBD	1	1	--
Subtotal, Clinician Recruitment and Service	155	300	173	295	+122
Health Professions					
Health Professions Training for Diversity:					
Centers of Excellence	13	TBD	21	25	+4
Scholarships for Disadvantaged Students	46	--	46	53	+7
Health Careers Opportunity Program	10	--	19	22	+3
Subtotal, Training for Diversity	68	--	86	100	+14
Training in Primary Care Medicine and Dentistry	48	--	48	56	+8
Interdisciplinary, Community-Based Linkages:					
Area Health Education Centers	28	--	33	33	--
Geriatric Programs	31	--	31	42	+11
Allied Health and Other Disciplines	9	--	14	24	+10
State Oral Health Workforce (non-add)	*5*	--	*10*	*20*	*+10*
Subtotal, Interdisciplinary, Community-Based Linkages	68	--	77	98	+21
Public Health Workforce Development:	8	--	9	9	--
Nursing Workforce Development:					
Advance Nursing Education	62	--	64	64	--
Nursing Workforce Diversity	16	--	16	16	--
Nurse Education, Practice and Retention	37	--	37	37	--
Nurse Faculty Loan Program	8	--	12	16	+5
Comprehensive Geriatric Education	3	--	5	5	--
Subtotal, Nursing Workforce Development	126	--	134	138	+5
Patient Navigator	3	--	4	4	--
Children's Hospital Graduate Medical Education Program	302	--	310	310	--
Subtotal, Health Professions	623	200	668	716	+48
Maternal & Child Health					
Maternal and Child Health Block Grant	666	--	662	662	--
Heritable Disorders	--	--	10	10	--
Congenital Disabilities	--	--	1	1	--
Autism and Other Developmental Disorders	36	--	42	48	+6
Traumatic Brain Injury	9	--	10	10	--
Sickle Cell Service Demonstrations	3	--	4	4	--
Universal Newborn Hearing Screening	12	--	19	19	--
Emergency Medical Services for Children	19	--	20	20	--
Healthy Start	100	--	102	102	--
Family-to-Family Health Information Centers (mandatory)	4	--	5	--	-5
Subtotal, Maternal and Child Health	849	--	876	877	+1

HEALTH RESOURCES AND SERVICES ADMINISTRATION

(dollars in millions)

	2008	2009 ARRA*	2009 Omnibus	2010	2010 +/- 2009 Omnibus
HIV/AIDS					
Emergency Relief - Part A	627	--	663	671	+8
Comprehensive Care - Part B	1,195	--	1,224	1,254	+30
AIDS Drug Assistance Program (non add)	*809*	--	*815*	*835*	*+20*
Early Intervention - Part C	199	--	202	212	+10
Children, Youth, Women, & Families - Part D	74	--	77	77	--
Education and Training Centers - Part F	34	--	34	38	+4
Dental Services - Part F	13	--	13	15	+2
Subtotal, HIV/AIDS	2,142	--	2,213	2,267	+54
SPNS Evaluation Funding	25	--	25	25	--
Subtotal, HIV/AIDS	2,167	--	2,238	2,292	+54
Health Care Systems					
Organ Transplantation	23	--	24	24	--
Cord Blood Inventory Program	9	--	12	12	--
C.W. Bill Young Cell Transplantation Program	24	--	24	24	--
Office of Pharmacy Affairs, 340B Program	--	--	1	3	+2
Poison Control Centers	27	--	28	28	--
State Health Access Grants	--	--	75	75	--
Preparedness Countermeasures Injury Comp. Prgrm.	--	--	--	5	+5
Subtotal, Health Care Systems	82	--	164	171	+7
Rural Health					
Rural Health Policy Development	9	--	10	10	--
Rural Health Outreach Grants	48	--	54	55	+2
Rural & Community Access to Emergency Devices	1	--	2	2	--
Rural Hospital Flexibility Grants	38	--	39	39	--
State Offices of Rural Health	8	--	9	9	+0.2
Delta Health Initiative	25	--	26	--	-26
Denali Project	39	--	20	--	-20
Radiogenic Diseases	2	--	2	2	--
Black Lung Clinics	6	--	7	7	--
CAHs to SNFs and Ast.Living Facilities (reimbursement)	5	--	--	--	--
Subtotal, Rural Health	180	--	169	125	-44
Public Health Improvement (Facilities and Other Projects)	304	--	310	--	-310
Telehealth	7	--	8	8	+1
Family Planning	300	--	307	317	+10
Program Management	141	--	142	147	+5
Vaccine Injury Compensation Program	5	--	5	7	+1
HEAL Direct Operations	3	--	3	3	--
National Practitioner Data Bank (User Fees)	20	--	20	20	--
Healthcare Integrity and Protection Data Bank (User Fees)	4	--	4	4	--
Total, Program Level	**6,923**	**2,500**	**7,296**	**7,190**	**-107**
Less Funds From Other Sources					
User Fees	25	--	24	24	--
PHS Evaluation Funds (HIV/AIDS)	25	--	25	25	--
CAHs to SNFs and Assisted Living Facilities (reimbursement)	5	--	--	--	--
Family-to-Family Health Information Centers (mandatory)	4	--	5	--	+5
Total, Budget Authority	**6,864**	**2,500**	**7,243**	**7,141**	**-102**
FTE	1,491		1,593	1,635	+42

*American Recovery and Reinvestment Act of 2009 (Recovery Act)

HEALTH RESOURCES AND SERVICES ADMINISTRATION

The Health Resources and Services Administration provides national leadership, program resources, and services needed to improve access to culturally competent, quality health care.

The FY 2010 Budget requests $7.2 billion for the Health Resources and Services Administration (HRSA), a net decrease of $107 million below FY 2009 due largely to the elimination of $361 million in earmarks. The Budget places an emphasis on improving access to health care in underserved areas, including an expansion of many of HRSA's health care workforce programs.

In FY 2010, HRSA programs and services will target:

- The 50 million underserved Americans who live in rural and poor urban neighborhoods where health care services are scarce;
- The over 45 million who lack health insurance- many of whom are racial and ethnic minorities;
- The more than 1 million people living with HIV/AIDS;
- State and Federal programs that provide services, public awareness and supportive services to the almost one million Americans who have Autism Spectrum Disorder.

IMPROVING ACCESS TO HEALTHCARE IN UNDERSERVED AREAS

Healthcare Professionals: The FY 2010 Budget includes $1 billion to support a wide range of healthcare professions programs that will immediately increase the number of providers practicing in underserved areas. These investments will also support students in professional schools, which will ensure that qualified clinicians are available to serve underserved populations in future years. Programs included as a part of the President's Initiative are the National Health Service Corps, the Nurse Loan Repayment and Scholarship Program, State Oral Health Workforce Program, and the Nurse Faculty Loan Program.

In support of the President's Initiative to strengthen the health professions workforce, the Budget includes $169 million, an increase of $34 million, for the National Health Service Corps (NHSC) to recruit and retain clinicians, including primary care, dental, behavioral, and mental health professionals, in communities of greatest need. Approximately 50 million Americans live in underserved communities, and lack adequate access to primary care service. Over its 38-year history, NHSC has offered scholarships and loan repayments to more than 28,000 health professionals in exchange for a commitment to serve the underserved. In FY 2010, the NHSC will support over 2,000 loan repayment and scholarship awards.

The Budget includes $263 million, an increase of $92 million, to address the shortage of nurses. The growing aging population, combined with increasing need for care, will create significant demand for nurses in the coming years. The Budget more than doubles the funding available for nurses serving in critical shortage facilities, which will support over 1,600 additional scholarship and loan repayment awards, along with the supporting an estimated additional 550 nurse faculty educators to ensure that nursing schools have the capacity to train the next generation of nurses.

Minority and disadvantaged health professionals are more likely to serve in areas with a high proportion of underrepresented racial and ethnic groups and to practice in or near designated health care shortage areas. Numerous studies have documented that increasing the number of minority health professionals as a key strategy to eliminating health disparities. The Budget includes $100 million for strengthening the Training for Diversity programs that increase opportunities for underrepresented minorities and financially disadvantaged students, an increase of $14 million. These funds will provide disadvantaged and

Recovery Act

On March 02, 2009 President Obama announced the release of $155 million in Recovery Act grant funds to support 126 Community Health Centers across the country. These grants alone will help provide health services to 750,000 Americans.

The Jackson Mississippi Clarion Ledger reports, "A $1.3 million federal health-care grant issued last week to Pearl-based Family Health Care Clinic makes it one of the first organizations in the state to benefit from the recently signed stimulus bill." The funding "will help open three health-care clinics in southwest Mississippi."

underrepresented minority students and faculty with opportunities to enhance their academic skills and obtain the support needed to graduate from health professions schools or faculty development programs.

The Budget provides $20 million, an increase of $10 million, in support of State efforts to improve and address their oral health workforce needs and $42 million, an increase of $11 million, in support of health care workforce programs that target geriatrics and better prepare for the aging population.

The FY 2010 Budget also includes $417 million for a range of other health professions programs that will strengthen and improve the pipeline of clinicians for future years, including $56 million in Primary Care Medicine and Dentistry, and $310 million for the Children's Graduate Medical Education (GME) program.

Improving Rural Health: The FY 2010 Budget includes $125 million to improve access to quality healthcare in rural areas. Within the total amount requested for Rural Health activities, the Budget includes $73 million for a new "Improve Rural Health Care" initiative to strengthen partnerships among rural health care providers, recruit and retain rural health care professionals, and modernize the health care infrastructure in rural areas.

The "Improve Rural Health Care" initiative includes:

- $55 million for Rural Health Care Services Outreach, Network, and Quality Improvement grants. These funds help existing rural networks improve the coordination of health services in rural communities and strengthen the rural health care system as a whole.
- $9 million for State Offices of Rural Health. This program provides technical and other assistance to rural health providers and helps rural communities recruit and retain healthcare professionals.
- $8 million for Telehealth grants to expand the use of telecommunications technologies within rural areas that increase access to and the quality of health care provided to rural populations

Funding also provided to improve chronic disease management options for patients in rural areas who suffer with cardiovascular diseases and diabetes. In 2007, Rural Outreach grantees provided services that focused on diseases and conditions with the greatest health disparities, and served over 923,000 individuals.

The Budget includes $19 million for Rural Health Policy Development, Black Lung Clinics, and Radiogenic diseases. These funds help conduct research on rural health issues and help inform policy recommendations for the Office of Rural Heath Policy.

Improving Rural Health Care

The FY 2010 Budget provides funding that supports the President's Initiative to improve the health care infrastructure in rural areas. Targeted programs within HRSA's Office of Rural Health Policy provide grants to improve the outreach and development of rural health centers, hospitals and public health departments in rural areas. Through telehealth projects, isolated rural areas have improved access to care and underserved areas receive expanded specialty services. HRSA also supports the direct placement of physicians, nurses and other providers in rural areas through NHSC scholarships and loan repayments.

PROTECTING UNINSURED AND AT-RISK POPULATIONS

Health Centers: Health Centers provide expanded access to care by helping people in need, many with no health insurance, obtain access to comprehensive primary and preventive health care services. In 2007, Health Centers served over 16 million patients. Seventy percent of Health Center patients live in poverty and 39 percent are uninsured. The FY 2010 Budget includes $2.2 billion to provide services that include addressing financial, geographic, cultural, linguistic, and other barriers to care.

Ryan White, HIV/AIDS: Each year the Ryan White HIV/AIDS program serves over 500,000 low-income people living with HIV/AIDS in the United States, many of whom are minorities and women. The FY 2010 Budget request includes $2.3 billion for Ryan White activities, an increase of $54 million above FY 2009. With these dollars, the Ryan White program will continue to address the care and treatment needs of persons living with HIV/AIDS in the United States who have no other access to health care services. The increased resources will provide additional support to States and metropolitan areas in meeting the needs of their local communities, and help provide life saving and extending medications to people with HIV/AIDS through the State AIDS Drug Assistance Program. The FY 2010 Budget also directs additional resources to increase access to oral health care

for people living with HIV/AIDS and to expand specialized HIV/AIDS education and training for primary care providers who serve uninsured and underinsured populations.

The 340B Drug Pricing Program: The Budget requests $3 million, an increase of $2 million for the 340B Drug Pricing program to help ensure that Federally-funded grantees and other health safety-net providers can purchase medication at significantly reduced prices. Nearly 14,000 "covered entities," including Health Centers, disproportionate share hospitals, and State ADAPs utilize this program. Funds will be used to improve the collection and analysis of manufacturer drug pricing information to ensure that 340B participants are charged accurate prices for drugs.

SUPPORTING HEALTHY FAMILIES

The Bureau of Maternal and Child Health and the Office of Family Planning provide quality healthcare and support to communities. The Budget will continue to provide services for low-income families and ensure access to preventive services.

Autism and Other Developmental Disorders: The Budget requests $48 million, an increase of $6 million for the President's Initiative to support children with autism spectrum disorders and their families and create opportunities and effective solutions for children with autism spectrum disorder. The funding will expand Federal and State programs authorized in the Combating Autism Act. The Budget will support research, screening and evidence-based interventions when a diagnosis is confirmed.

Family Planning: The FY 2010 Budget includes $317 million, an increase of $10 million, in support of the President's Initiative for prevention of teen pregnancy as well as the activities authorized in Title X of the Public Health Service Act, including family planning services, and preventive health services.

In 2007, Family Planning program served over 5 million patients, 69 percent who were at or below the Federal poverty level and 64 percent who were uninsured.

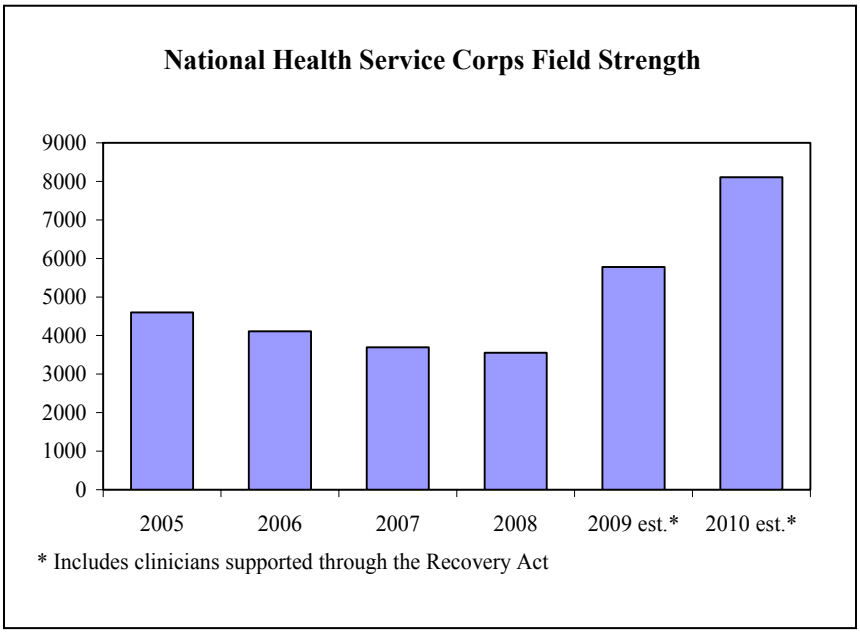
Maternal and Child Health Programs: The Budget provides $662 million for the Maternal and Child Health (MCH) Block Grant, which provides funding to States to improve the health of all mothers and children.

A total of $102 million is included for Healthy Start to provide services for high risk pregnant women, infants, and mothers in geographically, racially, ethnically, and linguistically diverse communities with high rates of infant mortality.

The FY 2010 Budget provides $64 million to continue support for several maternal and child health activities, including Traumatic Brain Injury, Sickle Cell Anemia, Congenital Disabilities, Newborn Screening for Hearing and Heritable Disorders, and Emergency Medical Services for Children.

OTHER ACTIVITIES AND PROGRAM MANAGEMENT

Preparedness Countermeasures Injury Compensation Program: The FY 2010 Budget includes $5 million for the Covered Countermeasures Process Fund, to support the administrative and claim costs associated with Public Readiness and Emergency Preparedness Act (PREP) declarations. The PREP Act provides liability protections for the countermeasures used to prevent and/or treat diseases or health conditions during a public health emergency. As of March 2009 there have been eight PREP Act declarations for pandemic influenza, anthrax, botulism, smallpox, and acute radiation syndrome. These resources will help ensure anyone harmed by these medical countermeasures will have access to compensation as specified in the PREP Act.



National Vaccine Injury Compensation Program: To address increases in the number of claims, as well as the court's requirement to begin the reviews of over 5,000 claims from the omnibus autism proceedings, the FY 2010 Budget includes $7 million for the Vaccine Injury Compensation Program. In FY 2008, HRSA completed 421 medical reports.

Supporting Transplantation: The FY 2010 Budget continues support for activities in organ, bone marrow, and cord blood stem cell transplantation through a combined investment of $60 million. Through a national system, the Organ Transplantation program allocates and distributes donor organs to individuals waiting for an organ transplant and supports efforts to increase the supply of donor organs. Similarly, the C.W. "Bill" Young Cell Transplantation Program provides support to patients who need a potentially life-saving marrow or cord blood transplant. In FY 2007 these programs helped to facilitate the donation of over 27,877 organs, and in FY 2008 increased the number of potential ethic and racial minority bone marrow donors to over 2 million.

The Budget request also includes $12 million for the National Cord Blood Inventory program which will be used to support the collection and purchase of approximately 8,500 new cord blood units.

Program Management: The Budget requests $147 million for program management. These resources will enable HRSA to effectively manage, monitor, and operate a wide array of activities as well as to fund Federal pay and rent increases.

(dollars in millions)

	2008	2009 ARRA*	2009 Omnibus	2010	2010 +/- 2009 Omnibus
Services					
Clinical Services:	3,228	85	3,424	3,748	+324
Contract Health Services (non add)	579	--	634	779	+145
Health Information Technology (non add)	--	85	3	16	+14
Preventive Health	128	--	135	144	+9
Contract Support Costs	267	--	282	389	+107
Tribal Management/Self-Governance	8	--	9	9	--
Urban Health	35	--	36	38	+2
Indian Health Professions	36	--	38	41	+3
Direct Operations	64	--	65	69	+4
Diabetes Grants	150	--	150	150	--
Subtotal, Services Program Level	3,916	85	4,139	4,588	+449
Facilities					
Health Care Facilities Construction	37	227	40	29	-11
Sanitation Facilities Construction	94	68	96	96	--
Facilities & Environmental Health Support	170	--	178	193	+15
Maintenance & Improvement	59	100	60	60	--
Medical Equipment	21	20	22	23	+1
Subtotal, Facilities Program Level	381	415	396	401	+5
Total, Program Level	**4,297**	**500**	**4,536**	**4,989**	**+454**
Less Funds From Other Sources					
Health Insurance Collections	-795	--	-799	-799	--
Rental of Staff Quarters	-6	--	-6	-6	--
Diabetes Grants 1/	-150	--	-150	-150	--
Total, Budget Authority	**3,346**	**500**	**3,581**	**4,035**	**+454**
FTE	15,014	--	15,144	15,254	+110

1/ These funds were pre-appropriated in P.L. 107-360 and the Medicare, Medicaid, and SCHIP Extension Act of 2007.

*American Recovery and Reinvestment Act of 2009 (Recovery Act)

INDIAN HEALTH SERVICE

The Indian Health Service raises the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

The FY 2010 Budget requests nearly $5 billion for the Indian Health Service (IHS), an increase of $454 million over FY 2009. The Budget request, which represents the largest proposed increase for the agency in the past 20 years, makes a crucial investment in the Indian health system to reduce the disparities experienced by American Indians and Alaska Natives. The Budget will provide funds to improve the Indian health system. IHS, in partnership with Tribes, provides primary care, behavioral and community health, and sanitation services for a growing population of eligible American Indians and Alaska Natives.

Fulfilling the Unique Role of the Indian Health Service

IHS provides comprehensive health services to members of more than 560 Federally-recognized Tribes through direct services in 45 hospitals, 288 health centers, and 313 health stations, school health centers, and Alaska village clinics. As part of the unique relationship between Tribes and the Federal Government, IHS provides American Indians and Alaska Natives with preventive health care and direct medical care, and contracts with hospitals and health care providers outside the IHS system to purchase care it cannot provide through its own network. IHS works with Tribes to ensure their maximum participation in administering the programs that impact their communities. In addition to the provision of health care services, IHS activities include building sanitation systems to provide water and waste disposal for Indian homes; supporting Tribal self-governance through contract funding; and providing scholarships and loan repayment awards to recruit health professionals, including American Indians and Alaska Natives, to serve in areas with high provider vacancies.

Reducing Resource Disparities in Service Provision: The Budget includes approximately $45 million for the Indian Health Care Improvement Fund, a significant investment aimed at creating parity in funding among service sites. Providing additional funds to service sites with the greatest resource deficiencies will help ensure that all eligible American Indians and Alaska Natives have access to quality health care.

Strengthening the Indian Health System

The Budget includes several increases to support and expand the provision of health care services and public health programs for American Indians and Alaska Natives, as well as building on the resources provided in the American Recovery and Reinvestment Act of 2009.

Population Growth and the Cost of Providing Care: The FY 2010 Budget request reflects a sustained investment in providing care to a growing population of American Indians and Alaska Natives. The Indian population is growing at a faster rate than the U.S. population as a whole, and the IHS service population is expected to increase by 1.5 percent in FY 2010. These increases are coupled with the rising cost of health care and salaries for Federal and Tribal employees who provide needed health services in often remote areas. The FY 2010 Budget includes $141 million to cover pay, population growth, and inflation.

Contract Health Services: IHS purchases health care from outside the IHS system in cases where no IHS-funded direct care facility exists, the direct care facility cannot provide the required emergency or specialty services, or the facility has more demand for services than it can meet. The Budget includes $779 million, an increase of $145 million, for the purchase of medical care, including essential services such as inpatient and outpatient care, routine and emergency care, and medical

Recovery Act

IHS received $68 million for Sanitation Facilities Construction, which will be used to build sanitation systems and provide American Indian and Alaska Native homes with potable water. In FY 2007, an estimated 36,000 American Indian and Alaska Native homes did not have access to a clean water supply.

Using Recovery Act funds, IHS estimates it will provide approximately 16,000 homes with safe, potable water, access to which can significantly reduce the incidence of gastroenteritis and other serious environmentally-related diseases.

support services, such as diagnostic imaging, physical therapy, and laboratory services. These funds are crucial to covering the cost of care for injuries, heart disease, digestive diseases, and cancer, some of the leading causes of death among American Indians and Alaska Natives.

Health Information Technology: IHS has been a recognized leader in health information technology and continues to develop and deploy innovative health IT tools that improve the lives of individual patients, populations and communities. The FY 2010 Budget includes $16 million to support administrative oversight and system maintenance requirements for the IHS health IT program, including the Resource and Patient Management System and the IHS electronic health record (EHR). These funds, used in conjunction with $85 million for Health IT provided in the Recovery Act, will allow IHS to invest in an expanding set of tools that enable and facilitate quality health care delivery through the utilization of information technology.

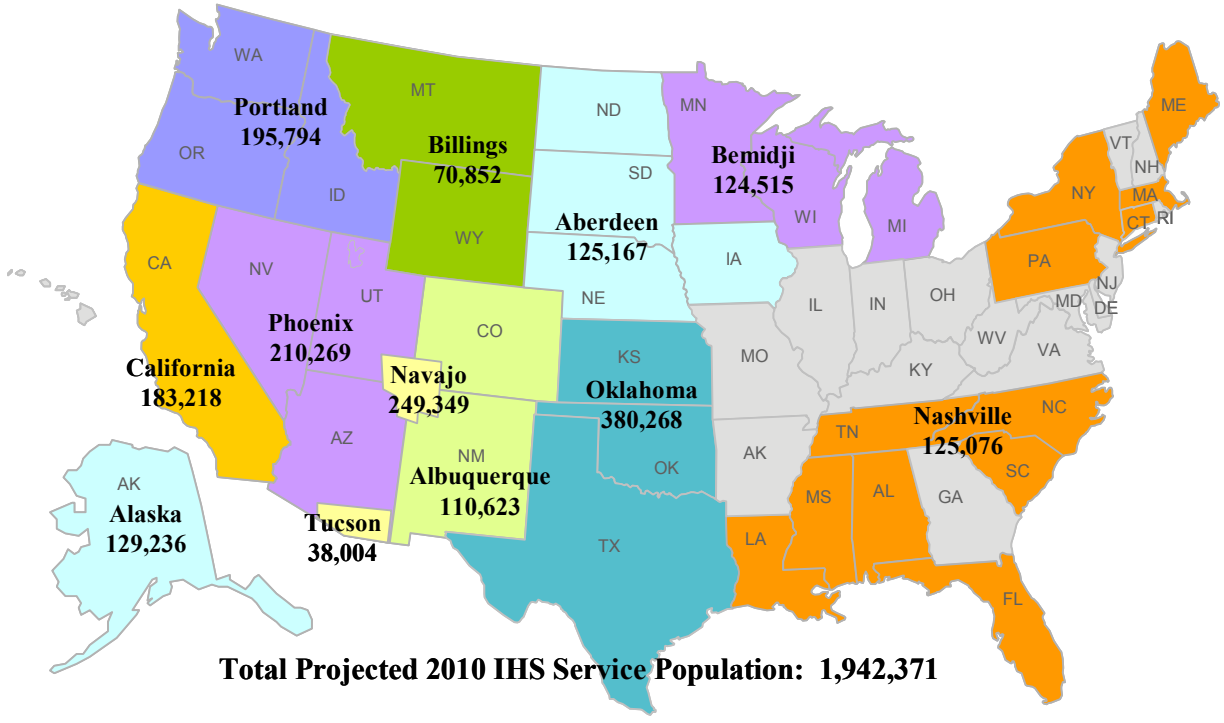
Construction: The Budget includes $29 million for Health Care Facilities Construction to continue construction of a hospital in Barrow, Alaska and two outpatient facilities in San Carlos and Kayenta, Arizona. Once completed, these facilities will serve a combined projected annual user population of 34,854 patients. The FY 2010 Budget builds upon $227 million provided in the Recovery Act to complete a hospital in Nome, Alaska, and an outpatient facility in Eagle Butte, South Dakota. The budget for facilities construction focuses on projects that have already been initiated.

Ensuring Access to Care

The FY 2010 Budget includes a significant increase to cover the cost of care purchased outside the IHS system, as part of the commitment to strengthen the Indian health system with sustained investments that improve health outcomes and expand access to care for American Indians and Alaska Natives.

In FY 2007, there were 35,154 Contract Health Services cases that could not be funded, often causing patients to delay or defer needed medical treatment or cover costly procedures out of pocket. The FY 2010 Budget request provides $779 million to cover the cost of patients receiving care they need outside the Indian health system.

Projected Indian Health Service Population by IHS Area/Region, CY 2010



Staffing New and Renovated Health Facilities: Construction and renovation funds for IHS health facilities have been targeted to expand services at sites experiencing overcrowding. These expansions require new staff and operating support. An additional $27 million is included in the FY 2010 Budget to support staffing and operating costs for four new or expanded facilities to be completed in FY 2010. These facilities include a hospital expansion in Ada, Oklahoma, and three health centers. All four facilities are joint venture projects, where IHS partners with a Tribal entity to provide funds for staffing, equipping, and operating a facility, and participating Tribes cover the costs of design and construction. When these facilities are fully operational, they will be able to meet the increasing demand for services at their sites, where the existing capacity is overextended.

Health Insurance Reimbursements: IHS facilities rely on the collection of third party resources for as much as 50 percent of their operating budgets. In FY 2010, IHS estimates it will receive approximately $799 million in health insurance reimbursements for the provision of care to people covered by Medicare, Medicaid, and private insurers. These funds are essential for covering the costs of hiring additional medical staff, purchasing equipment, making necessary building improvements, and maintaining accreditation standards.

Performance Highlight

Depression is often a factor contributing to suicide, domestic and intimate partner violence, and alcohol and substance abuse. Early identification allows providers to plan interventions and treatment to reduce the impact of depression, including the reduction of suicide rates, which are disproportionately high in Indian communities. In order to improve the mental health and well-being of American Indians and Alaska Natives, IHS increased the proportion of patients aged 18 and older who are screened for depression from 24 percent in FY 2007 to 35 percent in FY 2008.

SUPPORTING INDIAN SELF-DETERMINATION

IHS recognizes that Tribes and Tribal organizations are the most knowledgeable about the type of services needed in their own communities, and that the planning and delivery of health services at the local level ensures effective, quality health care. More than 54 percent of the IHS budget is administered by Tribes through the authority provided to them under the Indian Self-Determination and Education Assistance Act of 1975. The Act allows Tribes to assume the administration of programs that were previously carried out by the Federal Government.

Contract Support Costs: The Budget includes $389 million for contract support costs, an increase of $107 million. Contract support costs are defined as reasonable costs for activities that enable Tribes to develop the infrastructure needed to administer Federal programs. These funds provide Tribes with additional support in the operation of their own health programs. This investment will allow IHS to increase funding significantly to Tribes with existing self-determination agreements in order to ensure they have the resources they need to successfully manage programs at the local level.

Consultation: One of the key components of the government-to-government relationship with Tribes is consultation, in which Tribal governments and organizations play an integral role in the agency's budget and policy decision-making processes. In addition to extensive solicitation of Tribal input used to determine the way IHS operates at the local, area, and national level, HHS holds an annual department-wide budget consultation. This process gives Tribal leaders the opportunity to express their budget priorities, and continues to affirm the unique political and legal partnership between Tribes and the Federal Government.

CENTERS FOR DISEASE CONTROL AND PREVENTION

(dollars in millions)

	2008	2009 ARRA*	2009 Omnibus	2010	2010 +/- 2009 Omnibus
Infectious Diseases					
Immunization and Respiratory Disease	685	300	716	717	+1
Section 317 Discretionary Program (non-add)	*527*	*300*	*557*	*558*	+1
Pandemic Influenza (non-add)	*155*	--	*156*	*156*	--
Vaccines For Children	2,720	--	3,378	3,324	-54
HIV/AIDS, STDs & TB Prevention	1,002	--	1,006	1,060	+54
Zoonotic, Vector-Borne, and Enteric Diseases	68	--	68	73	+5
Preparedness, Detection, and Control of Infectious Diseases	150	--	157	169	+11
Subtotal, Infectious Diseases	4,624	300	5,326	5,343	+18
Health Promotion					
Chronic Disease Prevention & Health Promotion	834	--	882	896	+15
Birth Defects, Disability & Health	127	--	138	142	+4
Subtotal, Health Promotion	961	--	1,020	1,038	+19
Health Information and Service					
Health Statistics	114	--	125	139	+14
Informatics and Health Marketing	163	--	155	153	-2
Subtotal, Health Information and Service	277	--	279	292	+12
Environmental Health and Injury					
Environmental Health	154	--	185	186	+1
Injury Prevention & Control	135	--	145	149	+3
Subtotal, Health Information and Service	289	--	331	335	+4
Occupational Safety & Health	437	--	415	424	+8
Energy Employee Occupational Illness Compensation Program (non-add)	*55*	--	*55*	*55*	--
World Trade Center Treatment and Screening (non-add)	*108*	--	*70*	*71*	+1
Global Health	302	--	309	319	+10
Public Health Research	31	--	31	31	--
Public Health Improvement and Leadership	225	--	209	189	-21
Preventive Health and Health Services Block Grant	97	--	102	102	--
Buildings & Facilities	55	--	152	30	-122
Business Services Support	372	--	360	373	+13
Terrorism Preparedness and Emergency Response					
State and Local Capacity	746	--	747	761	+15
Upgrading CDC Capacity	121	--	121	121	--
Anthrax	8	--	8	--	-8
Biosurveillance Initiative	53	--	69	69	--
Strategic National Stockpile	552	--	570	596	+25
Subtotal, Terrorism Preparedness and Emergency Response	1,479	--	1,515	1,547	+32
Agency for Toxic Substances and Disease Registry	74	--	74	77	+3
User Fees	2	--	2	2	--
Subtotal, Program Level	9,227	300	10,124	10,102	-23
Less Funds Allocated from Other Sources					
Vaccines for Children (mandatory)	-2720	--	-3378	-3324	+54
Energy Employee Occupational Injury Compensation Program (mandatory)	-55	--	-55	-55	--
PHS Evaluation Transfers	-326	--	-331	-331	--
User Fees	-2	--	-2	-2	--
Total, Discr. Budget Authority	**6,124**	**300**	**6,357**	**6,389**	**+32**
FTE	8,951		9,646	9,797	+151

*American Recovery and Reinvestment Act of 2009 (Recovery Act)

CENTERS FOR DISEASE CONTROL AND PREVENTION

The mission of the Centers for Disease Control and Prevention is to promote health and quality of life by preventing and controlling disease, injury, and disability.

The FY 2010 Budget request for the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) is $10.1 billion, a decrease of $23 million from FY 2009. CDC is the primary Federal agency for conducting and supporting public health protection through promotion, prevention, preparedness, and research. The FY 2010 Budget request increases support for domestic HIV/AIDS prevention and treatment; for surveys and statistical analysis that are critical to public health programs at the Federal, State, and local level; for efforts to reduce health disparities, to detect and prevent autism, to prevent teen pregnancies and domestic violence; to detect emerging infectious disease; for global immunizations; and for the Strategic National Stockpile (SNS). The FY 2010 Budget request also includes reductions primarily focused on one-time projects funded in FY 2009.

In FY 2010, CDC will continue implementing Recovery Act activities for which CDC received funds in FY 2009. Specifically, CDC's continued implementation activities support expanded access to immunizations, the reduction of healthcare-associated infections, and community-based prevention and wellness activities.

PROTECTING THE NATION AGAINST INFECTIOUS AGENTS

The FY 2010 Budget includes a total of $2 billion in discretionary funding and $3.3 billion in mandatory funding for Infectious Diseases, including HIV/AIDS and immunization services for children and adults.

Recovery Act

The Recovery Act provided CDC $300 million for its Section 317 Immunization Grant Program to expand access to vaccines and vaccination services. In FY 2010, CDC will continue:

- expanding access to vaccination services to reach more children and adults;
- implementing demonstration projects for improving reimbursement and vaccination in schools and the community;
- conducting a national communication campaign;
- enhancing education of immunization providers; and
- strengthening the assessment of vaccine effectiveness, coverage, safety, and monitoring.

HIV/AIDS, Viral Hepatitis, STD and TB Prevention: The FY 2010 Budget provides $1.1 billion, $54 million above FY 2009, to develop, implement, and evaluate effective domestic prevention programs for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases (STD), and Tuberculosis (TB) Prevention.

The FY 2010 Budget request provides $744 million including pay, $53 million above FY 2009, for domestic HIV/AIDS prevention as part of an HHS initiative on HIV/AIDS prevention and treatment. This initiative provides increased resources to reduce HIV infections, increase access to care, and reduce health disparities. This increase will support CDC's domestic HIV/AIDS surveillance and testing, prevention research, capacity building and technical assistance, prevention interventions, and program evaluation and policy development. The increased resources for the initiative provide additional support for domestic HIV/AIDS testing through health departments and community-based settings to reduce the number of people infected that do not know their status.

In addition, the FY 2010 Budget requests $315 million for Viral Hepatitis, STD and TB prevention programs to support prevention, control services, surveillance, and research.

Immunization and Respiratory Diseases: Children can now be protected from more vaccine preventable diseases than ever before due to advances in biotechnology. In 1985, vaccines for seven diseases were available and recommended for routine use in children in the United States. Now, vaccines for 16 diseases are available and routinely recommended for children and adolescents. CDC's $4 billion immunization program has two components: the mandatory Vaccines for Children (VFC) program and the discretionary Section 317 program. The VFC program provides vaccines at no cost to children 18 years of age or younger who are Medicaid eligible, uninsured, American Indians and Alaska Natives, or who receive their immunizations at Federally qualified health centers and have health insurance that does not include coverage for vaccines.

Vaccines provided through the VFC program represent 43 percent of all childhood vaccines for 0-6 year olds and 26 percent of adolescent vaccines for 7-18 year olds purchased in the United States.

The discretionary Section 317 program provides funds to support State immunization infrastructure and operational costs as well as many of the vaccines public health departments provide to individuals not eligible for VFC, including adults. The FY 2010 Budget includes $558 million for the Section 317 program. In FY 2010, CDC will also continue implementation of Recovery Act investments in the Section 317 program begun in FY 2009 to expand access to vaccines and vaccination services.

Zoonotic, Vector-Borne, and Enteric Diseases: The FY 2010 Budget includes $73 million, $5 million above FY 2009, to provide national and international scientific and programmatic leadership for zoonotic, vector-borne, and enteric diseases. CDC identifies, investigates, diagnoses, treats and prevents diseases that are communicable from animals, pathogens, fungi, food and water to humans, including West Nile Virus, Lyme Disease and other special pathogens. This investment includes $32 million, $4 million above FY 2009, to facilitate improved data collection with Federal partners to investigate food-borne outbreaks more quickly and improve food safety.

Prevention, Detection, and Control of Infectious Diseases: The FY 2010 Budget requests $169 million, $11 million above FY 2009, to enhance CDC's ability to limit the impact of infectious diseases by detecting disease emergencies and outbreaks and providing epidemiological and operational response during these events.

In FY 2010, CDC will continue implementing healthcare-associated infection reduction strategies with Recovery Act funding provided in FY 2009. This investment will build upon the existing healthcare-associated infection activities of CDC to leverage the National Health Care Safety Network and support the dissemination of HHS evidence-based practices within hospitals to reduce these infections and save lives.

HIV/AIDS

The FY 2010 Budget increases resources for HIV/AIDS prevention to support detection, prevention, and treatment of HIV/AIDS domestically, especially in underserved communities. In FY 2007 (the most recent year data are available), the proportion of people with HIV diagnosed before progression to AIDS was 82.2 percent, which was an increase from the 79.7 percent diagnosed in FY 2006. As part of this initiative, the FY 2010 Budget includes $745 million, $53 million above FY 2009 for CDC's domestic HIV/AIDS activities. The FY 2010 Budget also includes increased funds in HRSA to support this initiative.

PROMOTING HEALTH AND PREVENTING CHRONIC DISEASE

The FY 2010 Budget for Health Promotion includes $1 billion, $19 million above FY 2009, for Health Promotion. The FY 2010 Budget includes $896 million, $15 million above FY 2009, for the Chronic Disease Prevention, Health Promotion, and Genomics activities and includes $142 million, $4 million above FY 2009, for Birth Defects, Developmental Disabilities, Disability and Health. These increased investments are key components of efforts to reform health care by enhancing early detection practices, surveillance, and prevention research. Chronic diseases are among the most prevalent, costly, and preventable of all health problems. Statistics show that the causes of 70 percent of birth defects and 75 percent of developmental disabilities are unknown. CDC works to identify and address the causes of birth defects and developmental disabilities and supports the development and evaluation of prevention and intervention strategies. Furthermore, CDC aims to prevent death and disability from chronic diseases; promote maternal, infant, and adolescent health; promote healthy personal behaviors and integrate genomics into public health research, policy, and programs.

Specifically, the increased FY 2010 investments in Health Promotion augment autism efforts at CDC, such as research, screenings, and treatment, and supports public awareness activities. This increase is part of a Presidential initiative to expand support for children, families, and communities affected by autism spectrum disorders. The FY 2010 Budget includes increased funds to HRSA and NIH to support the initiative across HHS. The increased investment will also support CDC activities in adolescent and school health and will support paralysis research related to the recently enacted Christopher and Dana Reeves Paralysis Act.

In addition, the increased FY 2010 investment in Health Promotion supports Presidential initiatives on the prevention of teen pregnancies. With these funds, CDC will engage

local communities in developing, implementing, and evaluating strategies and interventions to increase the capacity of national organizations and State teen pregnancy prevention coalitions to select, implement, and evaluate science-based approaches to prevent teen pregnancies.

In FY 2010, CDC will also continue Recovery Act investments to build communities' capacities to implement evidence-based prevention and wellness strategies that reduce the burden of chronic disease.

USING HEALTH INFORMATION AND SERVICE FOR PUBLIC HEALTH

The Budget for Health Information and Service includes $292 million, $12 million above FY 2009, for Health Statistics, Health Marketing, and Public Health Informatics. The FY 2010 Budget for Health Statistics includes $138 million, $14 million above FY 2009, to obtain and use statistics to understand health problems, recognize emerging trends, identify risk factors, and guide programs and policy. With all surveys and sample sizes funded, CDC will maintain its FY 2009 enhancements to national survey systems to ensure data availability on key national health indicators such as diet and nutrition, blood pressure, and mental health.

Public health informatics uses information systems and information technology to prevent diseases, disability, and other public health threats. The Public Health Informatics Budget request includes $71 million to continue efforts to define the needs for public health information systems, develop the standards that allow these systems to work together effectively, and design information systems and software that extend the capabilities of public health.

The FY 2010 Budget includes $83 million including pay, decrease of $2 million from FY 2009, for Health Marketing activities to focus resources on key health marketing activities that have demonstrated success, such as the CDC community guide and website.

ENVIRONMENTAL HEALTH AND INJURY PREVENTION AND CONTROL

The Budget includes $335 million, $4 million above FY 2009, for Environmental Health and Injury Prevention and Control activities. CDC's Environmental Health programs protect human health by preventing disability, disease, and death from environmental causes. The FY 2010 Budget provides $186 million to maintain CDC's level of assistance to States and local health agencies to build their capacities to address environmental health problems.

The FY 2010 Budget request includes $148 million, an increase of $3 million above FY 2009, for efforts to reduce premature deaths, disability, and the medical costs associated with injuries and violence, such as residential fire deaths, teen driving, traumatic brain injury, and child abuse and neglect cause. With this increased investment, CDC will enhance its activities to reduce domestic violence. Using the best available evidence, CDC will enhance its support of the identification of risk factors, the evaluation of prevention strategies, and the use of prevention approaches.

IMPROVING PREPAREDNESS AND RESPONSE TO TERRORISM

The Budget includes $1.5 billion, a net increase of $32 million, for CDC's terrorism preparedness and emergency response activities. The bioterrorism budget supports the Strategic National Stockpile (SNS), biosurveillance, and State and local preparedness efforts.

Strategic National Stockpile: The Budget focuses on ensuring a sufficient supply of countermeasures and other medical supplies to protect and care for victims of a bioterrorism attack or other public health emergency. The Budget includes $596 million for the SNS, an increase of $25 million, to finance the procurement of critical pharmaceuticals and vaccines needed to protect Americans from threat agents and support the capacity to deliver drugs, vaccines, and supplies anywhere in the Nation within 12 hours.

State and Local Preparedness: In FY 2010, $761 million is requested for State and local preparedness efforts, $15 million above FY 2009, bringing the total investment to over $7.5 billion since September 11, 2001. The Budget request also includes $30 million for the Centers for Public Health Preparedness, which is a network of 27 universities working with States and collaborating with one another to develop and support the public health emergency preparedness-related knowledge and skills of first responders and other public health professionals.

Biosurveillance: The FY 2010 Budget includes $34 million for BioSense, CDC's human health surveillance system. The funds will build on the progress made to date and help CDC implement connections with emerging Regional Health Information Organizations and Health Information Exchanges to implement case-based surveillance. The Budget provides $27 million to support the continued development

of 20 domestic quarantine stations, which help CDC prevent the spread of diseases that represent a significant public health risk. The Budget also includes $8 million for continued real-time lab reporting.

Upgrading CDC Capacity:
The FY 2010 Budget request includes $121 million, the same as FY 2009, for upgrading CDC capacity. These funds continue support of the Laboratory Response Network, the Select Agent Program, and research and surveillance on potential emergency situations such as biothreat agent releases. In addition, these programs ensure the ongoing evaluation and improvements of surveillance, laboratory science, research, and support throughout CDC and its grantees while continuing to advance public health preparedness and response capabilities through technical assistance, resource allocation, planning tools, education and training.

ADVANCING OCCUPATIONAL SAFETY AND HEALTH

The FY 2010 Budget provides $424 million for Occupational Safety and Health programs, $8 million above FY 2009. The National Institute for Occupational Safety and Health (NIOSH) is the primary Federal entity responsible for conducting research and making recommendations for the prevention of work-related illness and injury. NIOSH translates knowledge gained from research into products and services that improve workers' safety and health in settings from corporate offices to construction sites and coal mines. The increased investment of $5 million will support research on nanotechnology related to occupational health. Within the total for Occupational Safety and Health, $55 million in mandatory funding is included for CDC's role in the Energy Employees Occupational Illness Compensation Program.

Performance Highlight

Since 2004, the AIDS Program has worked in partnership with the State Department, USAID, and other federal agencies to provide AIDS prevention and control services as part of the President's Emergency Plan for AIDS Relief (PEPFAR). In 2008, the number of individuals receiving HIV/AIDS treatment through PEPFAR programs significantly increased to 2,007,800, up from 66,911 in 2003. The number of pregnant women receiving preventing mother-to-child transmission services significantly increased from 1,271,300 in 2004 to 5,850,100 in 2008. This performance gain can partially be attributed to momentum achieved through establishing local program infrastructure and systems in focus countries. Additional information regarding past performance and trends, current performance, and strategies can be found in the PEPFAR Fifth Annual Report to Congress at http://www.pepfar.gov/press/fifth_annual_report/index.htm.

The Budget also includes $71 million to support treatment and monitoring services for responders of the World Trade Center (WTC) attacks and for non-responders in the community directly affected by the attacks. Additional program expenses will be supported with funds from prior years. Currently, CDC funds six clinical centers and two data and coordination centers throughout the New York City metropolitan area. Based on the current spending rates and estimated carryover funds, HHS estimates that the FY 2010 Budget contains sufficient funding to support health care for those affected by WTC attacks.

GLOBAL HEALTH

The FY 2010 Budget includes $319 million, $10 million above FY 2009, for Global Health programs to protect the U.S. and world populations from emerging global threats. The additional investment of $10 million supports CDC's global immunization program to protect American children from vaccine-preventable diseases imported into the United States or acquired abroad. The FY 2010 Budget maintains support for CDC's other global health programs, including the Global AIDS program, which plays a vital role in CDC's implementation of its responsibilities under the President's Emergency Plan for AIDS Relief and the Global Disease Detection Program, which is designed to protect the health of Americans and the global community by rapidly detecting and responding to infectious disease outbreaks and other emerging health threats.

SUPPORTING PUBLIC HEALTH RESEARCH

Public Health Research provides evidence to support specific programs, practices, and policies that affect health decisions made by the American public and those responsible for health policies and programs. With funding of $31 million for health protection research, CDC is building a cadre of health protection researchers, research training programs, and centers of excellence that enable multidisciplinary approaches to public health practice.

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT

The FY 2010 Budget provides $102 million, the same as FY 2009, for the Preventive Health and Health Services Block Grant. These funds will support primary prevention activities and health services in States and local communities.

MANAGING CDC'S INFRASTRUCTURE AND HUMAN CAPITAL

The FY 2010 Budget includes $591 million in administrative and infrastructure activities to support CDC mission-critical efforts. The In addition, the FY 2010 Budget provides an increase of $22 million for pay, which is distributed across the CDC budget.

Business Services Support: CDC has improved and achieved efficiencies in its business and management operations and will continue to find ways to achieve higher performance at lower costs. The FY 2010 Budget includes $373 million, $13 million above FY 2009, for agency-wide operating costs, such as rent, utilities, and security.

Public Health Improvement and Leadership: The FY 2010 President's Budget includes $189 million, $21 million below FY 2009, for Public Health Improvement and Leadership. The decrease reflects the elimination of $21 million in one-time Congressional projects included in FY 2009. CDC's Public Health Improvement and Leadership activities support cross-cutting areas in CDC to ensure the effectiveness of public health programs and science. These funds also support CDC's public health workforce development program, which focuses on ensuring a competent and sustainable workforce prepared to meet current and emerging health promotion and protection priorities.

Buildings and Facilities: CDC has made remarkable progress on its 10-year Master Plan through its investments to build and upgrade facilities and laboratories. CDC's FY 2010 Budget for Buildings and Facilities is $30 million, a decrease of $122 million below FY 2009. This funding, coupled with unobligated balances, will allow CDC to conduct repairs and improvements and finish construction of priority infectious and environmental health labs.

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY (ATSDR)

The Budget request for ATSDR is $77 million, $3 million above FY 2009. Managed as part of CDC, ATSDR is the lead agency responsible for public health activities related to toxic substance exposures. The increase in FY 2010 supports epidemiologic studies of health conditions caused by non-occupational exposures to uranium released from past mining and milling operations on the Navajo Nation. Created in 1980 by the Comprehensive Environmental Response, Compensation and Liability Act – ATSDR leads Federal public health efforts at Superfund and other sites with known or potential toxic exposures. The Agency's mission is to use the best science, take responsive action, and provide trustworthy health information to prevent and mitigate harmful exposures and related disease. ATSDR continues to be at the forefront in protecting people from acute toxic exposures that occur from hazardous leaks and spills, environment-related poisonings, and natural and terrorism-related disasters.

NATIONAL INSTITUTES OF HEALTH
OVERVIEW BY INSTITUTE

(dollars in millions)

	2008	2009 ARRA*	2009 Omnibus	2010	2010 +/- 2009 Omnibus
Institutes					
National Cancer Institute	4,831	1,257	4,969	5,150	+181
National Heart, Lung & Blood Institute	2,938	763	3,016	3,050	+35
National Institute of Dental & Craniofacial Research	392	102	403	408	+5
Natl Inst. of Diabetes & Digestive & Kidney Diseases	1,866	445	1,911	1,931	+20
National Institute of Neurological Disorders & Stroke	1,552	403	1,593	1,613	+19
National Institute of Allergy & Infectious Diseases	4,583	1,113	4,703	4,760	+58
National Institute of General Medical Sciences	1,946	505	1,998	2,024	+26
Eunice K. Shriver Natl Inst. of Child Hlth & Human Dev	1,261	327	1,295	1,314	+19
National Eye Institute	671	174	688	696	+7
National Institute of Environmental Health Sciences:					
Labor/HHS Appropriation	646	168	663	684	+21
Interior Appropriation	78	19	78	79	+1
National Institute on Aging	1,053	273	1,081	1,093	+12
Natl Inst. of Arthritis & Musculoskeletal & Skin Dis	511	133	525	531	+6
Natl Inst. on Deafness & Communication Disorders	396	103	407	413	+6
National Institute of Mental Health	1,413	367	1,450	1,475	+24
National Institute on Drug Abuse	1,006	261	1,033	1,045	+13
National Institute on Alcohol Abuse & Alcoholism	439	114	450	455	+5
National Institute of Nursing Research	138	36	142	144	+2
National Human Genome Research Institute	489	127	502	510	+7
Natl Inst. of Biomedical Imaging & Bioengineering	300	78	308	313	+4
National Center for Research Resources	1,156	1,610	1,226	1,252	+26
Natl Center for Complementary & Alternative Med	122	32	125	127	+2
Natl Center on Minority Health & Health Disparities	201	52	206	209	+3
Fogarty International Center	67	17	69	69	+1
National Library of Medicine	330	84	339	343	+4
Office of the Director	1,112	1,337	1,247	1,183	-64
Buildings & Facilities	119	500	126	126	--
Total, Program Level	**29,615**	**10,400**	**30,553**	**30,996**	**+443**
Less Funds Allocated from Other Sources					
PHS Evaluation Funds (NLM)	-8	--	-8	-8	--
Type 1 Diabetes Research (NIDDK) 1/	-150	--	-150	-150	--
Total, Budget Authority	**29,457**	**10,400**	**30,395**	**30,838**	**+443**
Labor/HHS Appropriation	**29,380**	**10,381**	**30,317**	**30,759**	**+442**
Interior Appropriation	**78**	**19**	**78**	**79**	+1
FTE	17,255	--	17,534	17,886	+352

1/ These funds were pre-appropriated in P.L. 107-360 and the Medicare, Medicaid, and SCHIP Extension Act of 2007.

*American Recovery and Reinvestment Act of 2009 (Recovery Act)

NATIONAL INSTITUTES OF HEALTH

The National Institutes of Health uncovers new knowledge that will lead to better health for everyone.

The FY 2010 Budget requests $31.0 billion for the National Institutes of Health (NIH), an increase of $443 million, or 1.4 percent over the FY 2009 enacted level, excluding funds provided in the Recovery Act.

Substantial investment in biomedical research over the past 40 years, led by NIH, has successfully contributed to reducing the morbidity and mortality of many fatal conditions by improving treatments. This has changed the landscape of disease from acute to chronic diseases, which now account for over 75 percent of annual health care expenditures in the United States. The Nation has witnessed dramatic reductions in death rates from heart disease and stroke, declines in cancer incidence and mortality, increases in cancer survivorship, and improvements in the capacity to rapidly diagnose and control new infectious diseases shortly after they emerge.

NIH is the world's largest and most distinguished organization dedicated to maintaining and improving health through medical science. Its budget is composed of 27 appropriations for its Institutes and Centers, Office of the Director, and Buildings and Facilities. In FY 2010, about 84 percent of the funds appropriated to NIH will flow out to the extramural community, which supports work by more than 300,000 scientists and research personnel affiliated with over 3,100 organizations, including universities, medical schools, hospitals, and other research facilities. About 10 percent of the budget will support an in-house, or intramural, program of basic and clinical research activities managed by world-class physicians and scientists. This intramural research program, which includes the NIH Clinical Center, gives our Nation the unparalleled ability to respond immediately to national and global health challenges. Another 6 percent will provide for agency leadership, research management and support, and facilities maintenance and improvements.

ADDRESSING RESEARCH PRIORITIES IN FY 2010

In fulfilling its mission, NIH strives to maintain a diverse portfolio of research founded on both public health need and scientific opportunity. In FY 2010, the $31.0 billion Budget request, along with remaining Recovery Act funds, will pursue cross-cutting areas of discovery, support new research investigators, and continue programs for translating clinical research results into clinical practice.

The President's Budget for NIH highlights several initiatives.

Cancer: The FY 2010 President's Budget proposes to invest over $6 billion for cancer research across NIH, reflecting the first year of an eight-year strategy to double cancer research by FY 2017. The FY 2010 Budget request represents an increase of $268 million, or 5 percent, over estimated FY 2009 base cancer spending. NIH is formulating a strategic plan for the NIH-wide cancer doubling effort, with specific long-term and annual performance goals. This will ensure that the resources invested will have the greatest possible impact on developing innovative diagnostics, treatments, and cures for cancer.

Autism: As part of a $211 million HHS-wide initiative that would invest an additional $1 billion over the next eight years in autism-related activities, the NIH budget includes $141 million in FY 2010 for research into the causes of and treatments for autism spectrum disorders (ASD). For NIH, this represents an increase of $19 million, or 16 percent above the estimated base FY 2009 level. NIH expects to use these funds to help implement the objectives of the Strategic Plan for ASD Research, as developed by the Interagency Autism Coordination Committee. These objectives include identifying biomarkers;

Recovery Act

The Recovery Act provides a total of $10.4 billion for NIH to obligate within the next two years for the following:

- $8.2 billion for biomedical research.
- $1.3 billion for extramural research infrastructure, including laboratories and shared scientific equipment.
- $0.5 billion for NIH-owned facility construction and repairs and renovations.
- $0.4 billion for comparative effectiveness research.

improving ASD screening; establishing ASD registries; understanding genetic and environmental risk factors, as well as interactions between the immune and central nervous systems; and enhancing services that can help people with ASD across the lifespan.

Stem Cells: On March 9, 2009, President Obama issued Executive Order 13505 removing previous restrictions on Federal research involving human embryonic stem cells and directing NIH to expand support for human stem cell research. Within 120 days of the date of the Order, the Secretary, working through NIH, will review existing NIH guidance and other widely recognized guidelines on human stem cell research, including provisions establishing appropriate safeguards, and issue new guidance on such research consistent with the Executive Order. These guidelines have been drafted, and as of April 17, 2009, are open to public review and comment for 30 days before being issued. NIH will later estimate how much it will spend on human stem cell research in FY 2010 under the new guidelines. NIH estimates that support in this area will expand substantially, based on scientific opportunity and merit.

HIV/AIDS: NIH estimates it will devote nearly $3.1 billion for research on HIV/AIDS in FY 2010. Controlling and ultimately eliminating HIV/AIDS will require safe, effective vaccines and other preventive measures. Developing such vaccines remains a priority and one of NIH's greatest challenges. This effort will require significant advances in basic research to both better understand the virus and the disease and to develop new vaccine strategies. In addition to these funds, the budget for the National Institute of Allergy and Infectious Diseases includes $300 million, the same level as in FY 2009, as part of the United States Government's $900 million contribution to the Global Fund to Fight HIV/AIDS, Tuberculosis in FY 2010.

NIH Common Fund: The FY 2010 Budget allocates a total of $549 million, an increase of $8 million, or 1.5 percent over FY 2009, to continue support for trans-NIH Common Fund initiatives. These funds are included in the Office of the Director appropriation. This mechanism will continue to serve as an incubator for new projects that can overcome complex research barriers and accelerate the pace of discovery for new disease treatments, prevention strategies, and diagnostics across all Institutes and Centers.

New Investigators: The foundation of the research enterprise is talented, creative, and dedicated research personnel. Fulfilling the NIH mission requires that the agency sustain a vibrant extramural and intramural workforce, including sufficient numbers of new investigators with new ideas and new skills, especially in interdisciplinary fields of research. NIH is working to stem the trend of increases in the average age of first-time principal investigators obtaining independent research funding from NIH. NIH is aiming to have similar success rates between new investigators and new applications from established principal investigators. NIH will also focus on Early-Stage Investigators (i.e., a new investigator within 10 years of terminal degree or completion of medical residency). In FY 2010, NIH will modify data collection on the eRA Commons to better track and monitor this category of research applicant.

No funds are included in FY 2010 for the NIH Director's Bridge Awards (-$91 million), as Recovery Act funds are being used in FY 2009 and FY 2010 for similar purposes of supporting promising new and established researchers that may have otherwise just missed the cutoff line for grant awards.

Clinical Research Translation: To meet the profound challenges of 21st century medicine and capitalize on Common Fund initiatives, NIH developed a new Clinical and Translational Science Award (CTSA) beginning in FY 2006. These awards help advance information technology, integrate research networks, stimulate the development of computer-assisted outcome measurement, and improve workforce training. NIH will continue to transition elements of existing clinical research programs, primarily the General Clinical Research Centers (GCRCs)

Cancer Research

The President proposes to invest over $6 billion for cancer research across NIH, reflecting the first year of an eight-year strategy to double cancer research by FY 2017. Each year, over 1.4 million Americans are diagnosed with cancer and about 556,000 people die from it. Advances in cancer research are also expected to benefit a wide range of other disease areas across NIH. For example, developing advanced imaging technologies to refine diagnosis and tailor treatments, and developing micro-systems to target drug delivery to disease sites will benefit treatment strategies against both cancer and numerous other diseases, such as Alzheimer's and Parkinson's, to name just a few.

in the National Center for Research Resources (NCRR), into CTSAs as these programs complete their current funding cycles. In FY 2010, the total CTSA/GCRC program is estimated to be $467 million, including an increase of $20 million in new and reallocated funds within NCRR. Also within the total CTSA/GCRC program, $25 million will be provided from the Common Fund.

Research Project Grants

The $16.4 billion provided in FY 2010 for support of medical research through competitive, peer-reviewed, and investigator-initiated research project grants (RPGs) represents 53 percent of the total NIH Budget request. NIH estimates it will support 9,849 new and competing RPGs in FY 2010, an increase of 7 above the number estimated for FY 2009, excluding Recovery Act funds. The average cost of a new and competing research project grant in FY 2010 will be about $400,000, an increase of two percent above the FY 2009 estimate. The total number of RPGs to be supported in FY 2010 is expected to be 38,042, an increase of 171 over the FY 2009 non-Recovery Act level.

Extramural Research Facilities Construction and Renovation

No funds are requested in the FY 2010 Budget for extramural research facilities construction and renovation. In FY 2010, NIH will continue to award extramural facilities projects funded through the $1.0 billion provided in FY 2009 for this purpose in the Recovery Act.

Intramural Buildings and Facilities

A total of $133 million is requested for NIH Intramural Buildings and Facilities (B&F) in FY 2010, the same level as in FY 2009, to sustain and improve the physical infrastructure used to carry out quality biomedical research on the NIH campuses. This is in addition to the $500 million NIH received in the Recovery Act for intramural facilities construction and repairs.

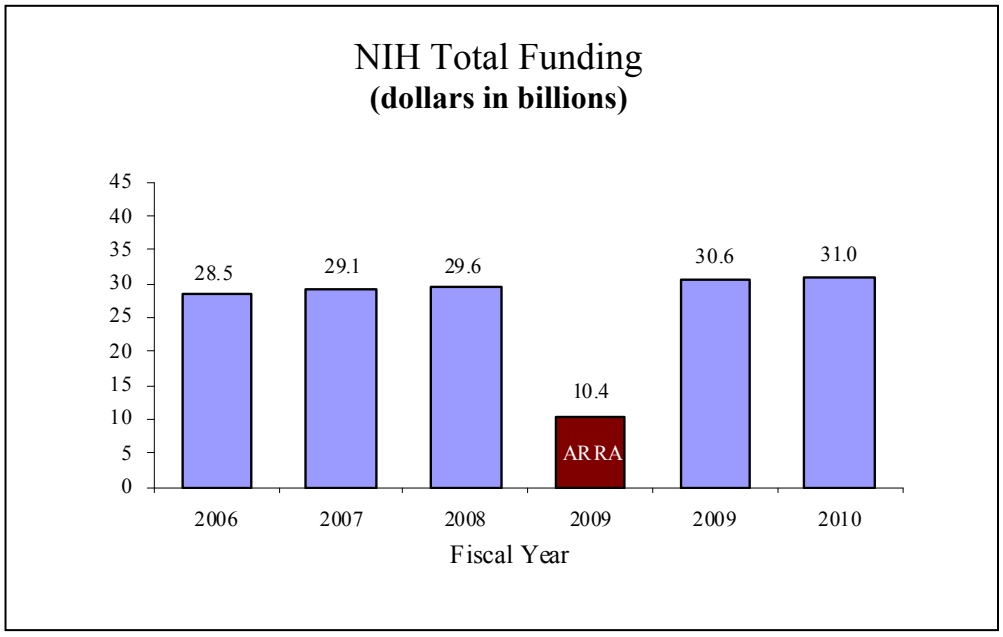
In FY 2010, NIH will focus on upgrading facilities to ensure essential safety and regulatory compliance, as well as on facility repairs and improvements to address the most critical utility systems, fire safety, and environmental deficiencies. The FY 2010 Budget request also includes $15 million to build an additional child care center on the NIH Bethesda campus. Within the B&F mechanism total, $8 million is appropriated to the National Cancer Institute for facilities projects at its Frederick, Maryland campus.

Performance Highlight

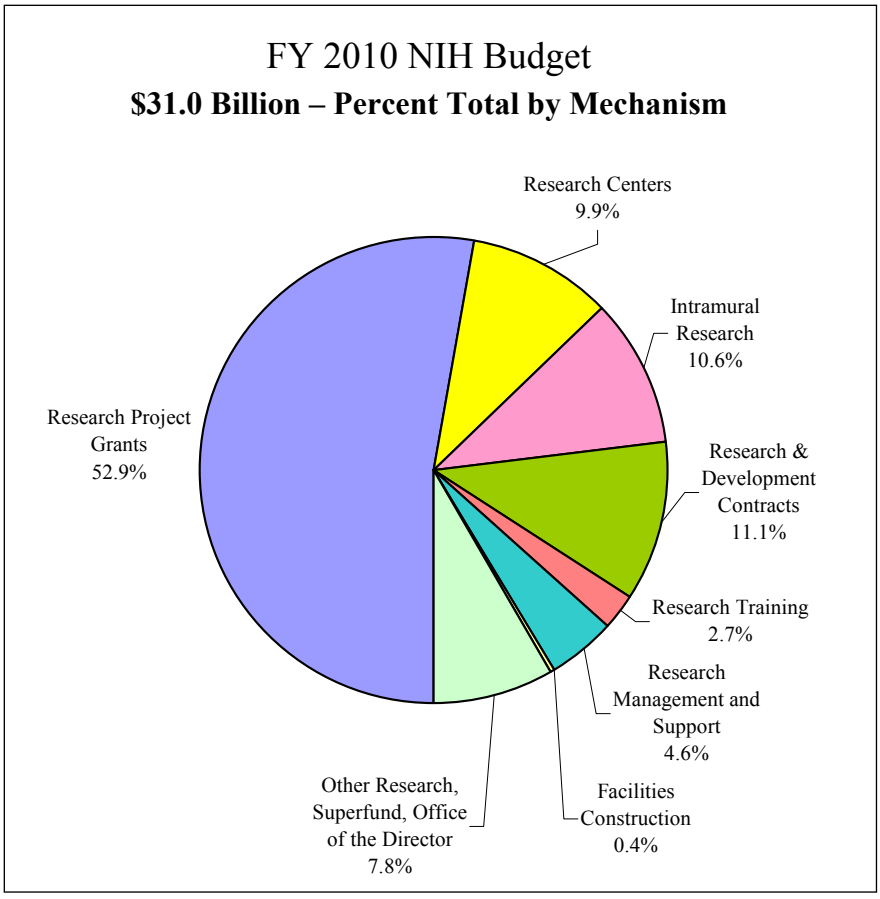
Goal: By 2009, NIH intended to identify one or two new medication candidates to further test and develop for treatment of tobacco addiction. About 440,000 deaths in the U.S. each year are attributed to cigarette smoking. Smoking cessation efforts report a failure rate of 75-90 percent.

NIH is currently conducting clinical trials and human lab studies on *four* candidate medications for tobacco addiction. These include:

- A nicotine vaccine using antibodies to block nicotine effects that is currently in a clinical trial. Preliminary results show a 36 percent quit rate compared to 14 percent for the placebo in the high antibody responders.
- An inhibitor (selegiline) of an enzyme (MAO-B) that contributes to the reinforcing effects of nicotine that is currently being tested in a patch formulation for improved delivery.
- A GABA agonist (pregabalin) to reduce nicotine's effects on the pleasure pathway that is currently being tested as a proof of concept.
- A glycine antagonist as a relapse prevention medication that is currently in a clinical trial comparing its effectiveness to bupropion and placebo.



American Recovery and Reinvestment Act (ARRA) funds are available for obligation in both FY 2009 and FY 2010.



NATIONAL INSTITUTES OF HEALTH
OVERVIEW BY MECHANISM

(dollars in millions)

Mechanism	2008	2009 ARRA*	2009 Omnibus	2010	2010 +/- 2009 Omnibus
Research Project Grants (dollars)	15,654	5,652	16,139	16,382	+243
[# of Non-Competing Grants]	*[26,610]*	*[5,414]*	*[26,195]*	*[26,333]*	*[+138]*
[# of New/Competing Grants]	*[9,714]*	*[7,679]*	*[9,842]*	*[9,849]*	*[+7]*
[# of Small Business Grants]	*[1,838]*	*[119]*	*[1,834]*	*[1,860]*	*[+26]*
[Total # of Grants]	*[38,162]*	*[13,212]*	*[37,871]*	*[38,042]*	*[+171]*
Research Centers	2,944	541	3,016	3,056	+40
Other Research	1,780	529	1,819	1,844	+25
Research Training	770	47	790	798	+8
Research & Development Contracts	3,270	791	3,378	3,411	+33
Intramural Research	3,096	32	3,180	3,227	+48
Research Management and Support	1,373	89	1,406	1,430	+25
Extramural Research Facilities Construction	--	1,000	--	--	--
Office of the Director	524	1,200	614	634	+19
[NIH Common Fund (non-add)]	*[498]*	*[137]*	*[541]*	*[549]*	*[+8]*
Buildings and Facilities	127	500	134	134	--
NIEHS Interior Appropriation (Superfund)	78	19	78	79	+1
Total, Program Level	**29,615**	**10,400**	**30,553**	**30,996**	**+443**
Less Funds Allocated from Other Sources					
PHS Evaluation Funds (NLM)	-8	--	-8	-8	--
Type 1 Diabetes Research (NIDDK) 1/	-150	--	-150	-150	--
Total, Budget Authority	**29,457**	**10,400**	**30,395**	**30,838**	**+443**
Labor/HHS Appropriation	**29,380**	**10,381**	**30,317**	**30,759**	**+442**
Interior Appropriation	**78**	**19**	**78**	**79**	**+1**
FTE	17,255	--	17,534	17,886	+352

1/ These funds were pre-appropriated in P.L. 107-360 and the Medicare, Medicaid, and SCHIP Extension Act of 2007.

*American Recovery and Reinvestment Act of 2009 (Recovery Act)

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

(dollars in millions)

	2008	2009 Omnibus	2010	2010 +/- 2009 Omnibus
Substance Abuse:				
Substance Abuse Block Grant	1,759	1,779	1,779	--
PHS Evaluation Funds (non-add)	*79*	*79*	*79*	--
Programs of Regional and National Significance				
Treatment	400	412	458	+46
PHS Evaluation Funds (non-add)	*4*	*9*	*9*	--
Prevention	194	201	198	-3
Prescription Drug Monitoring	--	2	2	--
Subtotal, Substance Abuse	2,353	2,394	2,437	+43
Mental Health:				
Mental Health Block Grant	421	421	421	--
PHS Evaluation Funds (non-add)	*21*	*21*	*21*	--
PATH Homeless Formula Grant	53	60	68	+8
Programs of Regional and National Significance	299	344	336	-9
Children's Mental Health Services	102	108	125	+17
Protection and Advocacy	35	36	36	--
Subtotal, Mental Health	911	969	986	+17
Program Management	93	100	102	+2
PHS Evaluation Funds (non-add)	*18*	*23*	*23*	--
St. Elizabeths Hospital	--	1	1	+0.02
Data Evaluation	--	3	--	-3
Program Level Total	**3,356**	**3,466**	**3,525**	**+59**
Less Funds Allocated from Other Sources:				
PHS Evaluation Funds	-122	-132	-132	--
Budget Authority Total	**3,234**	**3,335**	**3,394**	**+59**
FTE	544	549	549	--

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

The Substance Abuse and Mental Health Services Administration builds resilience and facilitates recovery for people with or at risk for substance abuse and mental illness.

The FY 2010 Budget requests $3.5 billion for the Substance Abuse and Mental Health Services Administration (SAMHSA), an increase of $59 million above FY 2009. The Budget continues Federal support for State and local efforts to increase the availability of quality prevention and treatment services for substance abuse and mental illness.

During the last decade more than 25 million people across the Nation used an illicit drug for the first time and more than 300,000 individuals died from suicide. The FY 2010 Budget invests in evidence-based prevention, early intervention, treatment, and recovery services to respond to these preventable and treatable public health problems. The Budget includes funding increases to expand the treatment capacity of drug courts, protect methamphetamine's youngest victims, improve children's mental health, and reach individuals suffering from mental illness who are facing homelessness. These programmatic increases are partially supported through the discontinuation of one-time projects that were funded in FY 2009.

SUBSTANCE ABUSE

Substance abuse affects individuals, families, schools, workplaces, and communities. In recognition that substance abuse prevents our Nation from achieving its full potential, the FY 2010 Budget includes $2.4 billion, an increase of $43 million, for effective substance abuse prevention and treatment activities.

Expanding the Treatment Capacity of Drug Courts: The Budget includes $59 million to expand the treatment capacity of drug courts, an increase of $35 million for this initiative. States and localities are increasingly using drug courts as an effective way of facilitating recovery and reducing criminal recidivism. Drug courts use close supervision, drug testing, sanctions, and incentives to ensure that offenders stick with their treatment plans and refrain from further criminal activity. The Budget provides resources to enable such courts to expand or enhance their treatment and recovery support services.

Making an Impact

The Winnebago County Drug Court was recently awarded a grant to enable it to expand its services to include a recovery coach, trauma support services, increased capacity for residential treatment, and more frequent drug testing. One participant in this program reports, "The drug court forced me to do something that I couldn't do for myself."

Through the FY 2010 initiative to expand the treatment capacity of drug courts, approximately 100 additional communities will receive Federal support to help clients like this turn their lives around.

Protecting Methamphetamine's Youngest Victims: Children with parents that use methamphetamine are at a heightened risk for abuse, neglect, and continued social and developmental problems. Within the increased funding for drug courts, $5 million will support families affected by methamphetamine abuse. Depending on their individual needs, children will receive early intervention and prevention services, mental health and child counseling, and other services to improve their safety and well-being.

Providing Access to Recovery: The Budget includes $99 million, the same level as FY 2009, to support States and Tribes in providing individuals facing substance abuse with a choice among various clinical treatment and recovery support service providers, including faith- and neighborhood-based providers. To date, 28 States and Tribes have received Federal support to develop consumer driven substance abuse treatment systems that empower clients to take responsibility for their own recovery. The FY 2010 Budget will expand the reach of this approach by supporting a new cohort of Access to Recovery grants.

Using Electronic Reporting to Prevent Addiction to Prescription Drugs: Prescription medications are highly beneficial treatments for a variety of health conditions. However, when abused, prescription medications can produce adverse health effects and lead to addiction. The Budget

includes $2 million, the same level as FY 2009, to support the establishment and improvement of State-administered controlled substance monitoring programs, as authorized by the National All Schedules Prescription Electronic Reporting Act of 2005. These programs will ensure that health care providers have access to accurate, timely prescription information that they can use as a tool for early identification of patients at risk of addiction.

Supporting Prevention and Treatment: The Budget includes $1.8 billion, the same level as FY 2009, for the Substance Abuse Prevention and Treatment Block Grant, which distributes funding to 60 States and jurisdictions to plan, implement, and evaluate substance abuse prevention and treatment services. At least 20 percent of this funding supports education and counseling to reduce the risk of substance abuse among individuals before they become addicted.

Providing Screening and Brief Interventions: The Budget includes $29 million to integrate substance abuse screening and interventions into general medical settings. This approach enables medical professionals to divert clients from a path that might otherwise lead to dependence and addiction, thereby avoiding significant health care and treatment costs.

Using a Strategic Framework to Prevent Substance Use: By the end of FY 2009, nearly every State and a number of Tribes and Territories will have received Strategic Prevention Framework State Incentive Grants to carry out needs assessments using epidemiological data, develop strategic plans to address the identified needs, and implement evidence-based prevention efforts. The FY 2010 Budget continues to support these activities through ongoing grants as well as through competitive supplemental awards for evidence-based programming. The Budget includes a total of $110 million for these efforts.

Reducing the Burden of HIV/AIDS Among Minority Populations: Behavioral health is integral to the prevention and treatment of HIV/AIDS. For instance, substance abuse is often linked to the transmission of new HIV/AIDS cases, and clients diagnosed with HIV/AIDS who experience mental disorders frequently do not receive mental health treatment that could improve their medical outcomes and quality of life. The Budget includes $117 million to foster behavioral health among African American, Latino, and other ethnic and racial minority populations experiencing disproportionate increases in HIV/AIDS.

MENTAL HEALTH

Untreated serious mental illness can make it difficult to hold a job, go to school, relate to others, and cope with ordinary life demands. The Budget includes $986 million, an increase of $17 million, for the prevention and treatment of mental illness.

Improving Children's Mental Health: The Budget provides $125 million, an increase of $17 million, for grants to States and localities to support the development of comprehensive community-based systems of care for children and adolescents with serious emotional disorders.

Assisting in the Transition from Homelessness: The Budget includes a total of $103 million, an increase of $8 million, for community-based services for individuals suffering from severe mental illness who are facing homelessness. This includes $68 million, an increase of $8 million, for the Projects for Assistance in Transition from Homelessness formula grant which is a flexible funding stream that allows local programs to use their grant funds in ways most appropriate to their communities to assist in the transition from homelessness. The total also includes $35 million to support services, in coordination with existing permanent supportive housing programs and in other community-level settings, for individuals and families experiencing chronic homelessness.

Performance Highlight

A national evaluation found that children receiving services through systems of care developed through the Children's Mental Health Services program demonstrated improved behavioral outcomes, better school performance, and fewer disciplinary and law enforcement encounters. These comprehensive results are achieved by integrating the efforts of previously fragmented child-serving systems into a single system of care. For example, within such a system, the teacher, coach, physician, and caregiver for a given student would work in a coordinated fashion to reinforce positive behavior and ensure the proper supports are available. Nearly 80 percent of the local systems of care established through this program have been sustained at least five years beyond the Federal grant period.

Supporting Community Mental Health Services: The Budget includes $421 million, the same level as FY 2009, for the Community Mental Health Services Block Grant. States use this flexible funding source to support infrastructure, service delivery, planning, and evaluation activities toward the development of a comprehensive community-based mental health service delivery system.

Preventing Youth Violence: The Budget includes $95 million for the prevention of youth violence. Through Safe Schools/Healthy Students, SAMHSA collaborates with the Departments of Education and Justice to help local partnerships draw on the best practices of education, justice, law enforcement, and social and mental health services to promote healthy child development and prevent violence. SAMHSA-supported interventions foster early childhood development of mental and physical health, reduce or delay the onset of emotional and behavioral problems, and treat children with serious emotional disturbance.

Preventing Suicide: The Budget includes $47 million specifically targeted to prevent suicide, which is a preventable public health problem. The Budget continues to support activities authorized by the Garrett Lee Smith Memorial Act which support intervention and prevention strategies in schools, institutions of higher education, juvenile justice systems, and other youth support organizations. The Budget also maintains a national hotline that routes calls from anywhere in the United States to a network of certified local crisis centers that can link callers to local emergency, mental health, and social service resources. In addition to these targeted resources, the broader investments made by SAMHSA in the prevention and treatment of mental and substance abuse disorders also play a key role in preventing suicide.

Protecting Individuals with Mental Illness: The Budget includes $36 million, the same level as FY 2009, to support States in protecting individuals with mental illnesses and serious emotional disturbances from abuse, neglect, and civil rights violations. The protection and advocacy systems that receive funding through this formula grant monitor residential treatment facilities and community-based facilities for children and youth. More than 80 percent of the substantiated complaints handled through these systems result in positive changes for their clients.

PROGRAM MANAGEMENT

The Budget includes $102 million, an increase of $2 million, for the administration of SAMHSA programs and the support of national data collection efforts. These resources will enable SAMHSA to continue to support States, Territories, and local organizations through grant and contract awards and to provide national leadership in promoting the provision of quality behavioral health services.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

(dollars in millions)

	2008	2009 ARRA*	2009 Omnibus	2010	2010 +/- 2009 Omnibus
Health Costs, Quality and Outcomes Research					
Patient Safety Research:					
Health Information Technology	45	--	45	45	--
General Patient Safety Research	34	--	49	49	--
Subtotal, Patient Safety	79	--	94	94	--
Comparative Effectiveness	30	700	50	50	--
Crosscutting Activities Related to Quality, Effectiveness, and Efficiency Research	157		160	160	--
Value	4		4	4	--
Prevention/Care Management	7	--	7	7	--
Total, Health Costs, Quality and Outcomes	277	700	314	314	--
Medical Expenditures Panel Surveys	55	--	55	55	--
Program Support	3	--	3	3	--
Total, Program Level	**335**	**700**	**372**	**372**	**--**
Less Funds From Other Sources					
PHS Evaluation Funds	-335	--	-372	-372	--
Total, Budget Authority	**--**	**700***	**--**	**--**	**--**
FTE	297	--	300	338	+38

*American Recovery and Reinvestment Act of 2009 (Recovery Act)

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

The Agency for Healthcare Research and Quality is charged with improving the quality, safety, efficiency, and effectiveness of health care for all Americans.

The FY 2010 Budget request for the Agency for Healthcare Research and Quality (AHRQ) is $372 million, the same amount as FY 2009, excluding Recovery Act funds. The FY 2010 Budget request maintains AHRQ's base funding for comparative effectiveness research; supports efforts to improve patient safety through investments in health IT and through a network of patient safety databases mandated by the Patient Safety and Quality Improvement Act of 2005; and provides funding for research on the organization, financing, and delivery of health care. The Budget request also supports data collection through Medical Expenditure Panel Surveys (MEPS) and other survey instruments.

AHRQ conducts and sponsors health services research to inform decision-making and improve clinical care and the organization and financing of health care. AHRQ evaluates both clinical services and the system in which these services are provided. This work contributes not only to improved clinical care, but also to more efficient and safer care. The agency's research agenda is broad and spans from medical informatics to health care system redesign, and from comparative effectiveness research to prevention and care management of patients with chronic conditions.

The Recovery Act appropriated $1.1 billion to AHRQ for comparative effectiveness research as part of the President's health reform agenda. AHRQ is required to transfer $400 million of the $1.1 billion to the National Institutes of Health. Of the remaining $700 million, $400 million is available for allocation at the discretion of the Secretary. AHRQ will invest the remaining $300 million in expanding its comparative effectiveness research activities.

HEALTH COSTS, QUALITY, AND OUTCOMES

The FY 2010 President's Budget provides a total of $314 million to support improvements through research on the cost, efficiency, and quality of health care. This includes investments in research on the comparative effectiveness of pharmaceuticals, medical devices, and health care services and their impact on health outcomes; health information technology; patient safety research; organization, financing, and delivery systems for safe and efficient health care; and reducing disparities in health care access and services.

Comparative Effectiveness Research: The FY 2010 Budget provides $50 million, the same as FY 2009, for comparative effectiveness research through AHRQ's Effective Health Care Program. Comparative effectiveness research improves health care quality by providing patients and physicians with state-of-the-science information on which medical treatments work best for a given clinical condition.

This program supports research on the outcomes of health care

Recovery Act

On March 19, 2009, HHS announced the members of the Federal Coordinating Council for Comparative Effectiveness Research (FCC). The purpose of the FCC is to foster optimum coordination of comparative effectiveness and related health services research conducted or supported by the relevant Federal departments and agencies. The FCC's goal is to reduce duplicative efforts and encourage coordinated and complementary use of resources.

Members of the FCC include representatives from:

- Agency for Healthcare Research and Quality
- Centers for Medicare and Medicaid Services
- Centers for Disease Control and Prevention
- Substance Abuse and Mental Health Services Administration
- Health Resources and Services Administration
- National Institutes of Health
- Office of the National Coordinator for Health Information Technology
- Food and Drug Administration
- HHS Office of the Secretary
- Veterans Administration
- Department of Defense
- Office of Management and Budget

services and therapies by comparing different therapies for a given clinical condition. The program has developed a process to generate new evidence, synthesize existing evidence, and translate research into user-friendly formats to inform health care decision-making. The Developing Evidence to Inform Decisions about Effectiveness (DEcIDE) Network conducts new research by analyzing information from electronic health information databases containing health data on over 50 million Americans. This information is used to compare the effectiveness and outcomes of treatments, improve effectiveness research, identify inappropriate drug prescribing patterns, evaluate the effects of benefits and formulary structure on health outcomes, and examine the clinical benefits of genetic testing.

AHRQ also supports the Centers for Education and Research on Therapeutics (CERTs) Program which conducts new research where limited information exists on the risks, benefits, and interactions of drugs, biologics, and medical devices. Evidence-based practice centers synthesize existing scientific literature, identify research gaps that the literature does not address, and recommend studies and approaches to fill the gaps. Finally, the Eisenberg Center translates research into user-friendly formats by developing plain language summary guides for each type of stakeholder: consumers, clinicians, and policymakers. The Center also creates web-based tools to improve patients' abilities to make health care treatment decisions. In FY 2010, AHRQ will also continue implementing Recovery Act comparative effectiveness research activities.

Comparative Effectiveness

Comparative effectiveness research is part of the President's health reform agenda. Comparing the effectiveness of medical treatments to give patients and physicians better information on what works best for patients with specific conditions is expected to improve patients' quality of health care.

Investing in Health IT: The FY 2010 Budget includes $45 million for health IT investments to develop and disseminate evidence and evidence-based tools about how health IT can be used to improve the quality, safety, efficiency, and effectiveness of care. AHRQ will use $29 million to continue its Ambulatory Safety and Quality program, including over $14 million for new grants to discover and evaluate how health IT can be used to improve care. AHRQ will invest over $15 million in its National Resource Center for Health IT and other efforts to translate and disseminate research into tools, technical assistance, and products that inform health IT implementation, use, and policymaking. The portfolio will develop and share best practices in the use of health IT to support patient-centered care, clinical decision support and improved decision-making, and the effective use of electronic prescribing and medication management. AHRQ will also synthesize findings from its recently completed grant program on the use of health IT by hospitals and other providers in rural, underserved, and safety net settings.

Supporting Other Patient Safety Activities: AHRQ's patient safety budget includes $49 million to support a variety of activities. Since FY 2006, AHRQ has provided funds to initiate activities authorized under the Patient Safety and Quality Improvement Act of 2005. This Act establishes patient safety organizations nationwide to collect information from providers about adverse events affecting patient safety. In FY 2010, these funds will allow AHRQ to continue its work creating a network of patient safety databases.

Performance Highlight

AHRQ plans to focus on best practices for healthcare-associated infection (HAI) prevention through disseminating proven techniques for reducing central-line associated blood stream infections in hospital intensive care units in 10 States. AHRQ will also initiate testing of similar techniques for other infection sites, such as catheter-associated urinary tract infections.

Each year, an estimated 250,000 cases of central line-associated bloodstream infections occur in hospitals in the United States, leading to at least 30,000 deaths, according to the Centers for Disease Control and Prevention. The average additional hospital cost for each infection is over $36,000, which totals over $9 billion in excess costs annually.

Results from this project can potentially improve care, save lives, and lead to substantial cost savings for participating hospitals and the health care system.

In FY 2010 AHRQ will also continue disseminating its best practices for healthcare-associated infections (HAI) prevention to States. AHRQ has provided funding for ten states to implement proven techniques for reducing central line associated blood stream infections in hospital intensive care units. This activity will help hospitals in their ongoing efforts to provide patients with the safest, highest quality care possible and reduce a known, serious problem with a high morbidity and mortality. In FY 2010, AHRQ will expand this effort to additional states and additional health care settings.

Supporting Research and Dissemination Activities Outside Patient Safety: In FY 2010, AHRQ will invest $170 million in research and dissemination activities in prevention care management, the delivery of healthcare services, and other research areas to support the quality and effectiveness of health care and ensure findings are accessible to the public. AHRQ will also continue to sponsor the United States Preventive Services Task Force in FY 2010.

MEDICAL EXPENDITURE PANEL SURVEYS (MEPS)

The FY 2010 Budget request for MEPS is $55 million, the same as FY 2009. MEPS collects detailed, national data on the health care services Americans use, how much they cost, and who pays for them. It is the only national source of individual, family, and visit-level information on medical expenditures. MEPS enables policy makers and researchers to model health disparities and the impact of health reform initiatives. MEPS data has been used by the Congressional Budget Office and by executive branch departments responding to Congressional inquiries regarding health care expenditures, insurance coverage, health initiatives, and source of payments. MEPS provides a better understanding of the quality of care the typical patient receives, and of disparities in the care delivered. MEPS data are critical for tracking the impact of Federal and State programs, including the Children's Health Insurance Program, Medicare and Medicaid.

(dollars in millions)

	2008	2009	2010	2010 +/- 2009
Current Law:				
Medicare /1	390,742	430,762	446,560	+15,798
Medicaid /2	201,426	262,389	289,764	+27,375
CHIP/3	6,900	8,566	10,095	+1,529
State Grants and Demonstrations	427	897	796	-101
Recovery Act Provisions (non-add)	--	*35,932*	*42,670*	--
Total Net Outlays, Current Law	**599,495**	**702,614**	**747,215**	**+44,601**
Current Policy:				
Baseline Adjustment to Physician Payments	--	--	11,713	+11,713
Administrative Adjustment for Physician Administered Drugs (non-add) /4	--	--	*2,030*	--
Total Net Outlays, Current Policy	**599,495**	**702,614**	**758,928**	**+56,314**
Proposed Law:				
Medicaid and CHIP	--	--	-1	-1
State Grants and Demonstrations	--	--	20	+20
Total, Proposed Law	**--**	**--**	**19**	**+19**
Total Net Outlays, Proposed Law /5	**599,495**	**702,614**	**758,947**	**+56,333**
Savings to Finance Health Reform:				
Medicare (non-add)	--	--	*-520*	*-520*
Medicaid (non-add)	--	--	*-1,450*	*-1,450*

1/ Current law Medicare outlays net of offsetting receipts.

2/ Net outlays net of Qualified Individuals.

3/ Includes the Child Enrollment Contingency Fund.

4/ Preliminary estimate assumed within baseline adjustment to physician payments.

5/ Total net proposed law outlays equal current law outlays plus the impact of proposed legislation and offsetting receipts. includes non-CMS administration.

CENTERS FOR MEDICARE & MEDICAID SERVICES

The Centers for Medicare & Medicaid Services ensures effective, up-to-date health care coverage and promotes quality care for beneficiaries.

The FY 2010 Budget request for the Centers for Medicare & Medicaid Services (CMS) is $758.9 billion in mandatory and discretionary outlays, a net increase of $56.3 billion over the FY 2009 level. This request finances Medicare, Medicaid, the Children's Health Insurance Program (CHIP), program integrity efforts, and CMS operating costs.

CMS is the largest purchaser of health care in the United States, serving 98 million Medicare, Medicaid, and CHIP beneficiaries.

RECENT LEGISLATION

The recent reauthorization of CHIP fulfills the President's commitment to expand CHIP coverage from 7.9 million in FY 2008 to over 12 million children in FY 2013. It expands CHIP and provides tools and incentives for States to strengthen and expand their CHIP programs.

The American Recovery and Reinvestment Act of 2009 protects health care coverage for millions of Americans during the recession by temporarily increasing Federal Medicaid funding to help States facing budget shortfalls to maintain their current programs.

The Recovery Act also includes $45 billion in funding to accelerate the adoption of electronic health records through incentives to Medicare and Medicaid providers starting in 2011.

HEALTH REFORM RESERVE FUND

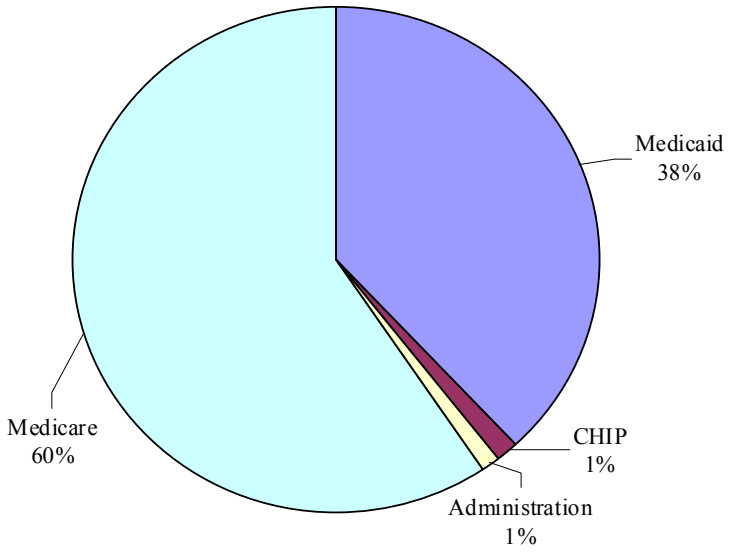
The Budget includes Medicare and Medicaid savings totaling $2.0 billion in FY 2010 and $309.1 billion over ten years to finance a portion of the health reform reserve fund. These proposals are designed to align incentives toward quality, promote efficiency and accountability, and encourage shared responsibility. The proposals are described in the Medicare and Medicaid sections.

BUDGET REQUEST

The CMS request also includes funding for the following priorities:

- A $311 million discretionary investment to combat health care fraud and abuse.
- $75 million in new mandatory funds for State high risk pools.
- A new $30 million investment for an expanded Medicare and Medicaid research agenda that will lay the groundwork for long-term reform of the health care system.
- $347 million for survey and certification to establish more frequent health facility surveys to protect beneficiary health and safety.
- The establishment of two permanent user fees to finance survey and certification activities.

CMS FY 2010 Net Outlays, Proposed Law /1
$758.9 billion



Note: State Grants and Demonstrations accounts for 0.11 percent of net outlays.
1/ Does not include $2 billion in Medicare and Medicaid savings to finance health care reform.

(dollars in millions)

	2008	2009	2010	2010 +/- 2009
Current Law:				
Outlays				
Benefits Spending (gross) /1	447,718	491,006	510,193	+19,187
Less: Premiums Paid Directly to Part D Plans /2	-2,840	-3,451	-4,191	-740
Subtotal, Benefits Net of Direct Part D Premium Payments	**444,878**	**487,555**	**506,002**	**+18,447**
Related-benefit Expenses/3	9,424	9,457	9,830	+373
Administration /4	6,625	7,485	7,758	+273
Recovery Act Provisions (non-add)	--	*442*	*140*	--
Total Outlays, Current Law (CL)	**460,927**	**504,496**	**523,590**	**+19,094**
Offsetting Receipts				
Premiums and Offsetting Receipts /5	-70,185	-73,734	-77,030	-3,296
Current Law Outlays, Net of Offsetting Receipts	**390,742**	**430,762**	**446,560**	**+15,798**
Current Policy				
Baseline Adjustment to Physician Payments	--	--	11,713	+11,713
Administrative Adjustment for Physician Administered Drugs (non-add) /6	--	--	*2,030*	--
Current Policy Outlays	**390,742**	**430,762**	**458,273**	**+27,511**
Medicare Savings to Finance Health Reform (non-add)	--	--	*-520*	*-520*

1/ Represents all spending on Medicare benefits by either the Federal government or beneficiaries.
2/ In Part D only, some beneficiary premiums are paid directly to plans and are netted out here because those payments are not paid out of the Trust Funds.
3/ Includes related benefit payments, including refundable payments made to providers and plans, transfers to Medicaid, and additional Medicare Advantage benefits.
4/ Includes Program Management, non-CMS administration, HCFAC, and QIOs. Of this total, $5.9 billion represents discretionary outlays for CMS and other agencies that support Medicare administration.
5/ Includes beneficiary premiums, State contributions to Part D, and other offsets.
6/ Preliminary estimate assumed within baseline adjustment to physician payments.

MEDICARE

In FY 2010, gross current law spending on Medicare benefits will total $510 billion. Medicare will provide health insurance to 47 million individuals who are either 65 or older, disabled, or have end–stage renal disease (ESRD).

THE FOUR PARTS OF MEDICARE

Part A ($186 billion in 2010):
Medicare Part A, or Hospital Insurance (HI), pays for inpatient hospital, skilled nursing facility, home health (related to a hospital stay), and hospice care. Part A financing comes primarily from a 2.9 percent payroll tax split between employees and employers.

Individuals with 40 quarters of Medicare-covered employment are entitled to Part A without paying a premium, but most services require a beneficiary co-payment or coinsurance. For example, in 2009, beneficiaries pay a $1,068 deductible for a hospital stay of 1-60 days, and $133.50 daily coinsurance for days 21-100 in a skilled nursing facility.

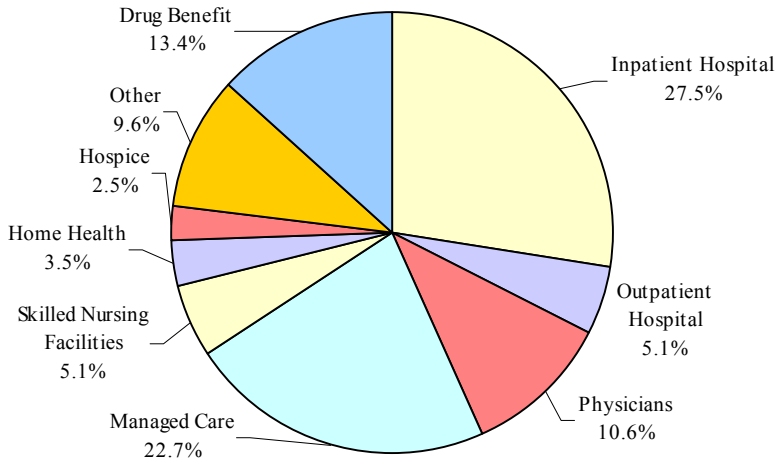
Medicare Enrollment
(enrollees in millions)

	2008	2009	2010	2010 +/-2009
Aged.....	37.6	38.2	38.9	+0.7
Disabled.....	7.4	7.5	7.7	+0.2
Total Beneficiaries	**45.0**	**45.7**	**46.6**	**+0.9**

Part B ($140 billion in 2010):
Medicare Part B, or Supplementary Medical Insurance (SMI), pays for physician, outpatient hospital, end-stage renal disease (ESRD), laboratory, durable medical equipment, certain home health, and other medical services. Part B coverage is voluntary, and about 94 percent of Medicare beneficiaries are enrolled in Part B. Approximately 25 percent of Part B costs are financed by beneficiary premiums, with the remaining 75 percent covered by general revenues.

Part B premiums are based on income. Most beneficiaries pay the standard monthly premium of $96.40 in 2009, which is unchanged from 2008. Some beneficiaries pay a higher premium based on their income: those with annual incomes above $85,000 (single) or $170,000 (married couple) will pay from $134.90 to $308.30 per month.

Medicare Benefits by Service, 2010
Current Law Estimate: $510.2 billion



Part C ($116 billion in 2010):
Medicare Part C, the Medicare Advantage (MA) program, offers beneficiaries a variety of coverage options including health maintenance organizations, preferred provider organizations, special needs plans, and private fee-for-service plans. MA enrollment totals more than 10 million of Medicare beneficiaries in 2009.

Medicare pays MA plans a capitated monthly payment to provide all Parts A and B services (and Part D if offered by the plan). Plans can also offer additional benefits or a variety of cost sharing arrangements. Beneficiaries pay

monthly premiums to MA plans to cover all Medicare services plus any additional benefits. The premium varies depending on the services offered by the plan; therefore, it can be higher or lower than the regular Part B premium.

Medicare currently pays more per beneficiary on average than it pays for a beneficiary in fee-for-service MA plans. MA payment rates are 14 percent higher on average than traditional fee-for-service rates. The extent of this difference has grown over time.

Part D ($68 billion in 2010): Medicare Part D offers a standard prescription drug benefit with a 2009 deductible of $295 and an average monthly premium of $28. The standard benefit includes a coverage gap in which beneficiaries are responsible for all of their drug costs, but once out-of-pocket spending reaches $4,350, Medicare covers 95 percent or more of drug costs. For people who are low income, varying degrees of cost sharing are available with co-payments ranging from $0 to $6.00 in 2009 and low or no monthly premiums.

As of 2009, about 90 percent of all Medicare beneficiaries, including over 10 million low-income beneficiaries, receive prescription drug coverage through Medicare Part D, employer-sponsored retiree health plans, or other creditable coverage. Fifty-nine percent of beneficiaries are enrolled in Part D plans; 39 percent have a prescription drug plan that offers a drug-only benefit package and 20 percent have an MA plan known as a Medicare Advantage-Prescription Drug plan that offers a combined benefit of medical services and prescription drugs.

FY 2010 LEGISLATIVE PROPOSALS

The Budget includes a comprehensive package of Medicare legislative proposals designed to strengthen the Medicare program by aligning incentives toward quality, promoting efficiency and accountability, and encouraging shared responsibility.

These Medicare legislative proposals contribute $520 million in 2010 and $287.5 billion over 10 years toward the reserve fund established by this Budget to finance fundamental reform of our health care system. Brief proposal descriptions follow.

Align Incentives Toward Quality

Hospital Quality Incentive Program: Pay hospitals an incentive payment based on the quality of care provided. The incentive payment would link a portion of base operating payments to performance on specified quality measures. The portion of payments linked to performance would be 5 percent in 2011, phasing to 15 percent by 2015.

Hospitals would earn quality incentive payments based on their performance on certain quality measures. Payments not earned back would be split equally between a pool to fund additional hospital quality incentive payments and the Medicare Trust Fund.

Reduce Hospital Readmissions: Adjust payments for targeted conditions and procedures by 30 percent for hospitals with readmission rates exceeding the 75th percentile, if the patient is readmitted within 30 days of discharge due to complication or related diagnosis, beginning in 2012. Public reporting of readmission rates would start in 2013.

Physician Bonus Eligible Organizations (BEOs): Enable physicians to form voluntary groups that coordinate care for

Medicare Prescription Drug Benefit Beneficiary Cost Sharing in 2009

Beneficiary Income Level	Annual Deductible	Monthly Premium	Beneficiary Out-of-Pocket Spending For Total Drug Expenditures:	
			≤ $6,154	> $6,154
≥150% FPL (standard benefit)	$295	$28 (avg)	25% from $295-2,700 100% from $2,700-6,154	Greater of 5% or $2.40-6.00 copay
135-150% FPL*	$60	$0-$31	15% from $60-6,154	Copayment of: $2.40 generic $6.00 brand
100-135% FPL*	$0	$0**	Copayment of: $2.40 generic $6.00 brand name	$0
≤100% FPL*	$0	$0**	Copayment of: $1.10 generic $3.20 brand name	$0

FPL=Federal Poverty Level

*At these income levels, beneficiaries must also meet an asset test.

**Monthly prescription drug premium will be $0 if beneficiary enrolls in a basic Part D plan with a premium that is below the low-income premium subsidy amount (or within $1 of the premium subsidy amount).

Medicare beneficiaries. BEOs would receive incentive payments if they improve the quality of care for patients and produce savings.

Influenza Vaccination: Create incentives for primary care physicians (PCP) to vaccinate Medicare beneficiaries. Payments would be reduced by 1.5 percent for PCPs who do not meet a benchmark rate of vaccination among beneficiaries receiving their services during the preceding flu season. PCPs would not be penalized if a flu shot is contraindicated or the beneficiary refuses.

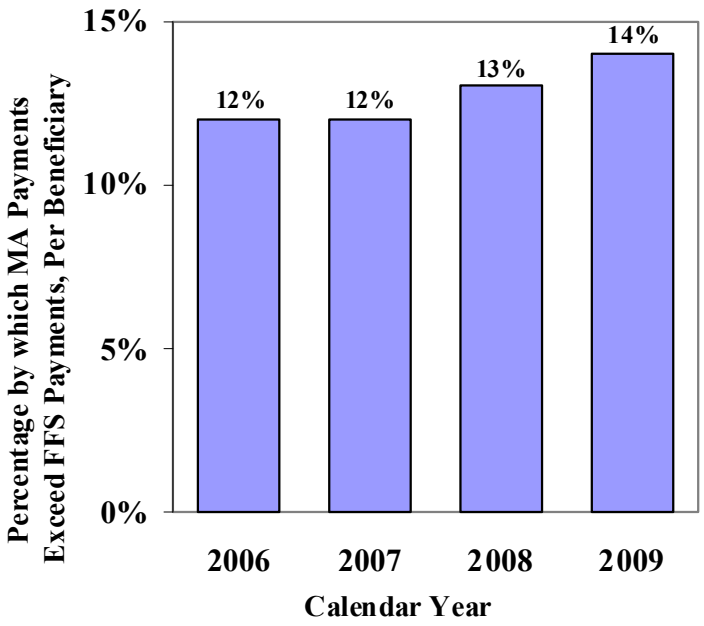
Promote Efficiency and Accountability

Competitive Bidding for Medicare Advantage Plans: Establish a competitive bidding system in which MA payments are based on the average of plan bids submitted to Medicare. MA benchmarks would be set equal to the average MA plan bid in each county. Bids would be weighted by plan enrollment in the previous year. This approach will allow the market, not Medicare, to set MA payment rates.

Bundled Medicare Payments: Promote the efficient and coordinated provision of care by bundling payments for inpatient hospital services and post-acute care within 30 days of discharge, beginning in 2013. A single payment would be made to hospitals to cover the costs of both acute and post-acute care services.

Physician-Owned Hospital Conflict of Interest: Prohibit new physician-owned hospitals from seeking reimbursement for services furnished to beneficiaries referred to the hospital by a physician with a financial interest in the hospital. Existing physician-owned hospitals would be grandfathered if they meet certain criteria, but prohibited from expanding.

Medicare Advantage Payments Exceed FFS Payments, on a Per Beneficiary Basis



Source: MedPAC

Imaging Services Payments: Require prior authorization from radiology benefit managers for the use and payment of advanced imaging services to control costs and guard against potential waste and abuse.

Home Health Payment Adjustments: Modify home health payments to better reflect the average cost of providing care by advancing a planned case-mix adjustment, providing a zero percent market basket update in FY 2010, and rebasing payments in FY 2011.

Improve Medicare Payment Accuracy: Promote payment accuracy and accountability in the Medicare program which would include: 1) providing Medicare contractors with resources to update their claims processing systems to better screen for payment errors; and 2) giving CMS the authority to require providers and suppliers to re-enroll on a more frequent basis.

Generic Biologics: Establish a workable regulatory, scientific and legal pathway for accelerated FDA approval of generic biologics. A period of exclusivity would be guaranteed for the original innovator product in order to retain incentives for research and development for the innovation of breakthrough products, which is generally consistent with the principles in the Hatch-Waxman law for traditional products. In addition, brand biologic manufacturers would be prohibited from reformulating existing products into new products to restart the exclusivity process, a practice known as "ever-greening." Expanding access to generic biologics will lead to Medicare and Medicaid savings.

Medicare and Medicaid Improvement Funds: Reallocate the Medicare and Medicaid Improvement Funds toward health care reform.

Encourage Shared Responsibility

Part D Premiums: Income-relate the Part D premium so that higher income beneficiaries will have their Part D premium increased on a sliding scale, using the same parameters in place under Part B and with income thresholds indexed annually for inflation.

FY 2010 MEDICARE ADMINISTRATIVE PROPOSALS

The Medicare budget includes administrative savings totaling $3.5 billion in FY 2010 and $27 billion over 10 years. These policies will be implemented through regulatory or subregulatory guidance:

- *Medicare Advantage Coding Intensity:* Adjusts MA risk score payments to bring coding intensity growth rates in line with FFS. MA risk scores have been rising faster than FFS risk scores because MA plans are more effective at coding than FFS, and this proposal adjusts for coding intensity differences. This policy was published on April 6, 2009.
- *Part D Normalization:* Implements a uniform, downward adjustment of Part D risk scores based on enrolled beneficiaries, as opposed to eligible beneficiaries. This approach will get the Part D program back to the original statutory intent of the government paying a 75 percent share and the beneficiary paying a 25 percent share of plan bids. This policy was published April 6, 2009.
- *Skilled Nursing Facility (SNF) Case Mix Recalibration:* Recalibrate case-mix indexes introduced in 2006 using actual data in the calculation rather than the projected data used initially with the introduction of nine new case-mix groups.

PHYSICIAN PAYMENTS

To promote more honest budgeting, the Budget also includes an adjustment totaling $311.1 billion over ten years to reflect the Administration's best estimate of what the Congress has done in recent years for physician payments. However, this adjustment does not suggest it should be a future policy.

The Administration believes that the current Medicare physician payment system, while having served to limit spending to a degree, needs to be reformed to give physicians incentives to improve quality and efficiency. As part of health care reform, the Administration would support comprehensive, but fiscally responsible, reforms to this payment formula. Consistent with this goal, the Administration will explore the breadth of options available under current authority to facilitate such reforms including an assessment, both substantively and legally, of whether physician administered drugs should be covered under the payment formula.

HIGHLIGHTS FROM THE MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT OF 2008

Physician Quality Reporting Initiative (PQRI): The PQRI program, under which physicians and other eligible professionals receive incentive payments for reporting data on quality measures, is extended through 2010.

Estimated Quality Improvement Organization Funding
by Major Task - 9th Contract Cycle (2008-2011)
(dollars in millions)

	Funds
Clinical Quality Improvement	
Prevention	115
Care Transitions	65
Patient Safety	225
Provider Performance	15
Protecting Beneficiaries/Case Review/Annual Payment Update Integration	
Case Review	171
Annual Payment Update Reviews	28
Infrastructure, Support and Special Initiatives	
Theme Implementation/Support Infrastructure	48
QIO Standard Data Processing	189
Other Support Contracts/Special Projects	245
Total, QIO Ninth Cycle of Contracts	**1,099**

Note: Funding levels have been rounded.

Electronic Prescribing: Medicare physicians will receive incentive payments for using electronic systems to order prescription drugs. Starting in CY 2011, CMS will phase-out these incentive payments and phase-in payment penalties for prescribers not using electronic systems.

Health Care Fraud and Abuse Control (HCFAC)
(dollars in millions)

	2010	2011	2012	2013	2014	2010-2014
Mandatory Base Funding	1,172	1,172	1,172	1,172	1,172	5,860
Proposed Discretionary Funding	311	327	343	361	381	1,723
Total Program Level	**1,483**	**1,499**	**1,515**	**1,533**	**1,553**	**7,583**
Savings from Discretionary Investment:	**-485**	**-520**	**-538**	**-564**	**-608**	**-2,714**

ESRD Bundled Payments and Pay-for-Performance: CMS will implement a bundled payment system for ESRD services starting in 2011. In addition, CMS will develop an ESRD pay-for-performance system.

MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS (QIO)

QIOs assist providers seeking to improve the quality of care delivered to Medicare beneficiaries and respond to beneficiary complaints about the quality of care received and identify inefficiencies in health care. These quality improvement efforts are essential to the Administration's goals to modernize and strengthen the Medicare program.

9th Statement of Work (SOW): Between 2008 and 2011, approximately $1.1 billion will be provided to QIOs under the 9th SOW. This SOW includes significant reforms to the management of the program and increases the expected performance of the QIOs. The major goals of the 9th SOW include preventing illness, increasing the safety of care provided, reducing health care disparities, and promoting the use of efficient and high quality care. The 9th SOW will measurably reduce illness, injury, and re-hospitalization.

Clinical Quality Efforts: Under the 9th SOW, clinical care efforts will focus on preventing disease, improving the coordination of care to avoid unnecessary rehospitalizations, identifying and intervening in the area of health care disparities, and increasing patient safety. In addition to the clinical quality efforts, QIOs will continue to protect beneficiaries by responding to quality of care complaints and making information available to support public reporting.

New Performance Management Strategy: The 9th SOW includes several innovations in QIO contract management, including ongoing performance management reviews, mid-contract performance assessments, and financial consequences if contractors do not maintain pre-specified performance levels.

PROGRAM INTEGRITY OVERSIGHT

Health Care Fraud and Abuse Control (HCFAC): The FY 2010 Budget proposes to continue funding the HCFAC program through both mandatory and discretionary funding streams. The FY 2010 HCFAC program level is nearly $1.5 billion, $125 million more than in FY 2009. Of this total program level, approximately $1.2 billion is mandatory and $311 million is discretionary.

HCFAC Mandatory Funds: The $1.2 billion in mandatory funds are financed from the Medicare Part A Trust Fund. This funding is allocated into three major parts: 1) the Medicare Integrity Program (MIP); 2) the Federal Bureau of Investigation (FBI); and 3) the HCFAC Account, which is divided among the Department of Justice (DOJ), the HHS Office of Inspector General (OIG), and other HHS agencies annually. Activities financed by this funding are used to detect and prevent heath care fraud, waste and abuse through investigations, audits, educational activities, and data analysis.

Combating Health Care Fraud

The Budget fulfills the President's commitment to strengthen efforts to combat health care fraud and abuse with a $311 million discretionary investment.

Mandatory HCFAC funding has a proven record of returning money to the Medicare Trust Fund for each dollar spent. For MIP, the actual return on investment (ROI) is 13 to 1, and for the HCFAC Account, the ROI is 4 to 1. From 1997 to 2007, HCFAC activities (excluding MIP)

have returned over $11 billion to the Trust Fund. MIP activities have yielded an average of almost $10 billion annually in recoveries, claims denials, and accounts receivable over the past decade. In FY 2007, over $425 million in Medicare recoveries was returned to the Trust Fund and approximately $266 million in Medicaid recoveries was returned to the Treasury as a result of program integrity efforts.

For 2010, the Budget proposes to streamline HCFAC administration by splitting the current funding provided jointly to HHS and DOJ into separate funding streams and changing the due date of the annual HCFAC report from January 1 to June 1.

HCFAC Discretionary Funds: As part of a government-wide proposal to fund proven program integrity activities through an adjustment to discretionary spending totals, the FY 2010 Budget requests $311 million in discretionary HCFAC funding. This total will be allocated as follows:

- Medicare ($220.32 million)
- Medicaid ($31.10 million)
- DOJ ($29.79 million)
- OIG ($29.79 million)

The 2010 HCFAC investment represents the first year of a multi-year strategy.

These funds will complement the program integrity activities funded with mandatory HCFAC dollars.

Moreover, the additional funding will better equip the Administration to minimize inappropriate payments, close loopholes, and provide greater value for program expenditures to beneficiaries and taxpayers.

Based on the proven success of the mandatory HCFAC program, it is expected that this additional discretionary investment will also aid in the reduction of improper payments and recoup many times its initial investment. It is currently estimated that for every new dollar spent by HHS to combat health care fraud, $1.55 is saved or averted. The HCFAC discretionary proposal will yield $2.7 billion in mandatory Medicare and Medicaid savings over five years.

MEDICARE PROPOSALS

(dollars in millions)

	2010	2010-2014	2010-2019
Medicare Proposals to Finance Health Care Reform			
Align Incentives Toward Quality:			
Encourage Hospitals to Reduce Readmission Rates	0	-2,450	-8,430
Create Hospital Quality Incentive Payments	0	-2,980	-12,110
Encourage Primary Care Physicians to Administer the Flu Vaccine	0	0	0
Enable Physicians to Form Voluntary Groups that Coordinate Care	*	*	*
Subtotal, Align Incentives Toward Quality	0	-5,430	-20,540
Promote Efficiency and Accountability:			
Establish Competitive Bidding for Medicare Advantage	0	-47,590	-177,200
Bundle Payments Covering Hospital and Post-Acute Settings	0	-820	-16,100
Address Financial Conflicts of Interest in Physician-Owned Hospitals	*	*	*
Ensure Appropriate Payments for Imaging Services using Radiology Benefit Managers	0	-70	-250
Improve Home Health Payments to Align with Costs	-460	-12,150	-34,070
Improve Medicare Payment Accuracy	-60	-750	-2,100
Establish Pathway for FDA Approval of Generic Biologics /1	0	20	-6,000
Reallocate Medicare Improvement Fund	0	-23,130	-23,130
Subtotal, Promote Efficiency and Accountability	-520	-84,490	-258,850
Encourage Shared Responsibility:			
Establish Income Related Part D Premium Consistent with Part B Policy	0	-2,410	-8,070
Subtotal, Encourage Shared Responsibility	0	-2,410	-8,070
Total, Medicare Proposals to Finance Health Care Reform	**-520**	**-92,330**	**-287,460**
Medicare Administrative Policies			
Medicare Advantage Coding Intensity Adjustment	-2,400	-3,300	-3,300
Normalize Part D Risk Scores Based on Enrolled Beneficiaries	-260	-2,080	-5,710
SNF PPS Recalibration of Case-Mix Indexes	-840	-7,230	-18,000
Total, Medicare Administrative Policies	**-3,500**	**-12,610**	**-27,010**
Total, Medicare Budget Proposals and Policies	**-4,020**	**-104,940**	**-314,470**

* Estimate not yet available.

1/ The Administration continues to analyze the potential for additional Federal savings.

MEDICAID

(dollars in millions)

	2008	2009	2010	2010 +/- 2009
Current Law:				
Benefits /1	191,510	250,368	277,382	+27,014
State Administration	9,917	12,021	12,381	+360
Recovery Act Impact (non-add)/2	--	*35,490*	*42,530*	--
Total Outlays, Current Law	**201,426**	**262,389**	**289,764**	**+27,374**
Proposed Law:				
Medicaid Proposed Law Savings/3	--	--	-1	-1
Total Net Outlays, Proposed Law	**201,426**	**262,389**	**289,763**	**+27,373**
Medicaid Savings to Finance Health Reform (non-add):	**--**	**--**	***-1,450***	***-1,450***

1/ Includes Vaccines for Children Outlays.
2/ Represents the impact of the American Recovery and Reinvestment Act of 2009 on the level of Benefits and State Administration in the Medicaid program. For more information please see the Recovery Act Chapter.
3/ These savings represent decreased Medicaid outlays from the Administration for Children and Families Home Visitation legislative proposal.

Federal and State Governments jointly fund Medicaid, a mandatory spending program that provides medical assistance to certain low-income groups. The Federal Government's share of a State's medical assistance expenditures is called the Federal medical assistance percentage (FMAP). The FMAP has a floor rate of 50 percent. For FYs 2009, 2010, and part of 2011, FMAP rates are adjusted to reflect temporary increases enacted by the American Recovery and Reinvestment Act (Recovery Act).

In FY 2010, HHS estimates that approximately 53 million individuals in States and Territories will be covered by Medicaid. These individuals include children, the aged, blind, and/or disabled, and people who meet eligibility criteria under the former Aid to Families with Dependent Children (AFDC) program, as well as many other individuals who are eligible for benefits through waivers and amended State plans with somewhat higher income eligibility limits. In FY 2010, the Federal share of current law Medicaid outlays is expected to be $290 billion. This is a $27 billion (10.4 percent) increase over projected FY 2009 spending.

According to the first Medicaid Actuarial Report, released in 2008, total medical assistance payment spending, including State share, is projected to increase at an annual rate of 7.9 percent over the next ten years and to reach $674 billion by 2017. Total Medicaid outlays represented 14.8 percent of all United States health care spending in 2006.

How Medicaid Works

States are required to cover individuals who meet categorical and financial eligibility levels. This includes individuals who qualified under the previous AFDC rules;

Recovery Act
Temporary Increase in Medicaid FMAP

The American Recovery and Reinvestment Act of 2009 provided a temporary increase in the Federal medical assistance percentage (FMAP) for all States and the District of Columbia, and an adjustment to allotment caps for Territories. This temporary increase has three components:

- Hold harmless provision – base FMAP rate cannot decrease in FYs 2009, 2010, or the first quarter of 2011.
- 6.2 percentage point FMAP increase for all States.
- Additional increases based on the severity of unemployment in each State.

most Supplemental Security Income (SSI) recipients; pregnant women and children under age 6 whose family income is at or below 133 percent of the Federal poverty level (FPL); and children ages 6 to 19 whose family income is below the FPL, all of whom are commonly referred to as "the categorically eligible."

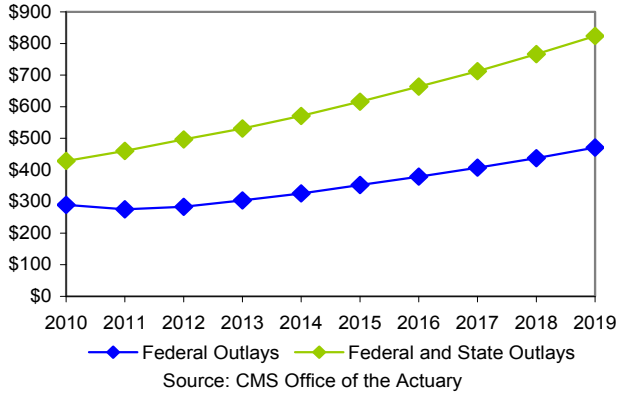
States may also cover medically needy individuals. These individuals meet the categorical eligibility criteria, but have too much income or too many resources to meet the financial criteria. This includes, but is not limited to, pregnant women through a 60-day post-partum period, children under age 18, newborns, and certain protected blind individuals. For 2009, the FPL for a family of four is $22,050 in the continental United States. For more information, see http://aspe.hhs.gov/poverty/09poverty.shtml.

The President's Budget includes $1.5 billion in savings to Medicaid in FY 2010 and $22 billion over ten years. These savings will increase efficiency and accountability in Medicaid and will help contribute to the needed overhaul of our nation's health system. The President's proposals slow the average annual growth in Medicaid over the next five years from 4.4 percent to 4.3 percent.

FY 2010 Legislative Proposals

The President's Budget aims to improve efficiency and accountability in the Medicaid program by reducing prescription drug payments for Federal and State governments, increasing access to family planning services for low-income women, and improving Medicaid program integrity.

Estimated State and Federal Medicaid Outlays
FY 2010-2019
(dollars in billions)



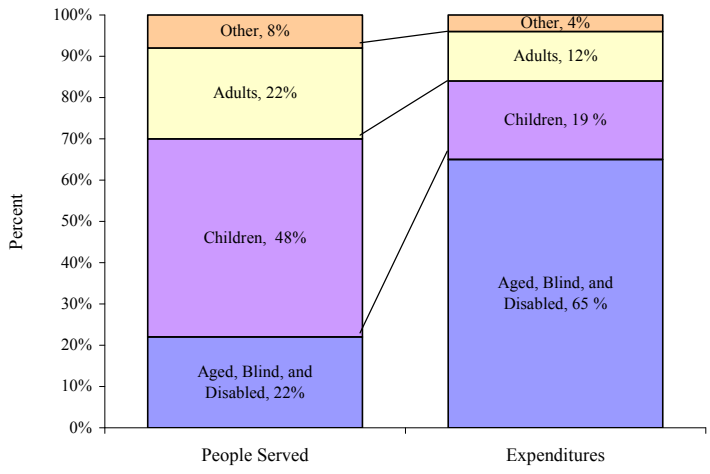
Source: CMS Office of the Actuary

Increase the Minimum Medicaid Brand-name Drug Rebate from 15.1 Percent to 22.1 Percent: Increases the savings to Medicaid from brand-name drug rebates paid by drug manufacturers by increasing the rebate amount from its current level of 15.1 percent to 22.1 percent of average manufacturer price.

Extend Drug Rebates to Medicaid Managed Care Organizations: Authorizes States to collect rebates from drug manufacturers on drugs provided through Medicaid managed care organizations (MCOs) and plans. The rebate structure would be the same as those collected for the fee-for service component of Medicaid. Currently, under an MCO arrangement, manufacturers are not required to pay the statutory rebates on drugs purchased by MCOs for Medicaid beneficiaries.

Apply Medicaid Additional Rebate to New Formulations of Existing Drugs: Addresses the current loophole that enables drug manufacturers to circumvent the

Distribution of People Served through Medicaid Payments by Basis of Eligibility, FY 2006



Source: Medicaid Statistical Information System, FY 2006, CMS.
Note: Data for ME FY 2004 and NV FY 2005 substituted for missing FY 2006

additional rebate by creating new formulations of drugs and charging higher initial prices for these drugs.

Establish a Pathway for FDA Approval of Generic Biologics: This FDA legislative proposal would also create savings to the Medicaid program by reducing costs of biologics.

Mandate National Correct Coding Initiative (NCCI): Promotes correct coding by providers and prevents inappropriate billing for services that have been improperly coded.

Expand Medicaid Family Planning Services: Promotes efficiency in the Medicaid program by providing a State option to expand family planning services to non-pregnant women between ages 15 and 44 who have family income at or below 200 percent of the Federal poverty level. This proposal will improve access to family planning services and help to avoid unplanned pregnancies, resulting in savings to States and the Federal Government.

Reallocate the Medicaid Improvement Fund: Eliminates the Medicaid Improvement Fund and reallocates these savings to support broader reform of health care.

RECENT PROGRAM DEVELOPMENTS

American Recovery and Reinvestment Act of 2009 (P.L. 111-5)

Incentives for Adoption of Health Information Technology: Provides a 100 percent Federal match for incentive payments to Medicaid providers for the adoption of health information technology and a 90 percent Federal match for State administrative expenditures. The Act also provides implementation funding for CMS.

Temporary Increase in the Federal Medical Assistance Percentage (FMAP): Provides a hold harmless for State FMAP rates and increases all FMAPs by 6.2 percentage points through December 31, 2010, with additional FMAP increases for States that experience high unemployment growth.

Temporary Increase in Disproportionate Share Hospital (DSH) Allotments: Amends Title XIX to increase State DSH allotments by 2.5 percent for fiscal years 2009 and 2010.

Extension of Congressional Moratoria on Certain Medicaid Regulations: Extends moratoria on Medicaid final regulations pertaining to optional case management services, allowable provider taxes, and school-based administration and transportation services until July 1, 2009, and establishes a new moratorium on the outpatient hospital services final regulation until July 1, 2009.

Extension of Transitional Medical Assistance (TMA) and Qualified Individuals (QI) Programs: Extends the TMA and QI programs through December 31, 2010.

Protections for Indians under Medicaid and CHIP: Provides protections for Indians under the Medicaid and CHIP programs including requirements for managed care organizations, limits on cost-sharing, and exclusion of certain property for purposes of determining eligibility.

Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) - Medicaid Provisions

Extension of Disproportionate Share Hospital (DSH) Allotment Adjustments: Amends Title XIX to extend the Medicaid DSH allotments for Tennessee and Hawaii, with specified adjustments through December 31, 2011.

Numerous provisions in the Children's Health Insurance Program Reauthorization Act of 2009 apply to both Medicaid and CHIP. Please refer to the CHIP chapter for detailed descriptions of these provisions.

Medicaid Enrollment

(enrollees in millions)

	2008	2009	2010
Aged 65 and Over	4.6	4.7	4.8
Blind and Disabled	8.3	8.6	8.9
Children	23.3	24.9	26.2
Adults	11.0	11.9	12.4
Territories	1.0	1.0	1.0
Total	**48.2**	**51.1**	**53.3**

Source: CMS Office of the Actuary Estimates

Performance Highlight

Increase the number of States that demonstrate improvement related to access and quality health care through the Medicaid Quality Improvement Program: CMS has a long-term measure tracking the number of States participating in the Medicaid Quality Improvement Program, which seeks to help States achieve safe, effective, efficient, timely, equitable, and patient-centered care. CMS has a target of nine States participating in FY 2009, and ten States by FY 2010. The program was first implemented in FY 2007, the baseline year.

(dollars in millions)

	2010	2010 -2014	2010 -2019
Medicaid Proposals to Finance Health Care Reform			
Increase Medicaid Brand-name Drug Rebate from 15.1% to 22.1%.....	-250	-2,120	-5,090
Extend Drug Rebates to Medicaid Managed Care Organizations.....	-770	-3,810	-8,770
Apply Additional Rebate to New Formulations of Existing Drugs.....	-150	-1,270	-3,050
Interaction of Medicaid Drug Rebate Proposals.....	-270	-1,320	-3,040
Mandate National Correct Coding Initiative.....	-10	-175	-620
Expand Medicaid Family Planning Services.....	--	-5	-65
Pathway for FDA Approval of Generic Biologics: Medicaid Impact.....	--	-10	-350
Reallocate Medicaid Improvement Fund.....	--	-100	-700
Total, Medicaid Proposals to Finance Health Reform	**-1,450**	**-8,810**	**-21,685**
Medicaid and CHIP Interactions			
Phase-in Home Visitation: Medicaid and CHIP Impact/1.....	-1	-81	-668
Total, Medicaid and CHIP Savings	**-1**	**-81**	**-668**

1/ The Home Visitation legislative proposal is discussed in the Administration for Children and Families section of the Budget in Brief.

CHILDREN'S HEALTH INSURANCE PROGRAM

(dollars in millions)

	2008	2009	2010	2010 +/- 2009
Current Law:				
Children's Health Insurance Program.....	6,900	8,466	9,895	1,429
Child Enrollment Contingency Fund.....	--	100	200	100
Total Outlays	**6,900**	**8,566**	**10,095**	**+1,529**

The Balanced Budget Act of 1997 (BBA) (P.L. 105-33) created the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. The BBA appropriated almost $40 billion in mandatory funding to the program over 10 years (FY 1998 through FY 2007). The program was extended by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173) through March 2009.

The Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) reauthorized the CHIP program through FY 2013, providing an additional $44 billion in funding over five years and creating several new initiatives to increase innovation and enrollment in the program.

How CHIP Works

CHIP is a partnership between Federal and State Governments that helps provide low-income children with the health insurance coverage they need. The program improves access to health care and quality of life for millions of vulnerable children 19 years of age and under. In general, CHIP reaches children whose families have incomes too high to qualify for Medicaid, but too low to afford private health insurance.

States with an approved CHIP plan are eligible to receive an enhanced Federal matching rate, which ranges from 65 to 85 percent, drawn from a capped allotment.

States have a high degree of flexibility in designing their programs. They can implement CHIP by:

- Expanding Medicaid;
- Creating a new, non-Medicaid Title XXI separate State program; or
- A combination of both approaches.

Implementation and Enrollment

Since September 1999, every State, the District of Columbia, and all five Territories have had approved CHIP plans. As of April 2009, States and Territories have received approval for 12 Medicaid expansion programs, 18 separate programs, 26 combination programs, and 328 State plan amendments.

In FY 2008, total CHIP enrollment at some point during the year was 7.9 million. This represents an increase of approximately 200,000, or 2.3 percent, over FY 2007 enrollment.

Recent Program Developments

Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3)

The reauthorization of CHIP provides an additional $44 billion

CHIP Reauthorization

Reauthorization of the CHIP program provided many improvements and enhancements that will increase health care coverage for low-income children:

- Provides $44 billion over five years in additional funding for States.
- Establishes a Child Enrollment Contingency Fund to relieve State funding shortfalls.
- Creates Performance Bonus Payments to award States for increasing enrollment of eligible children.
- Provides optional coverage for low-income pregnant women.
- Establishes a Child Health Quality Initiative to improve health care outcomes for children.
- Requires dental benefits and mental health parity in CHIP programs.

to increase CHIP coverage from 7.9 million in FY 2008 to over 12 million children in FY 2013. It expands CHIP and provides tools and incentives for States to strengthen and expand their CHIP programs.

Increased CHIP Allotments to States: Provides an additional $44 billion in State allotments for CHIP programs over five years. The reauthorization also shortened the period of availability of CHIP allotments from three years to two years.

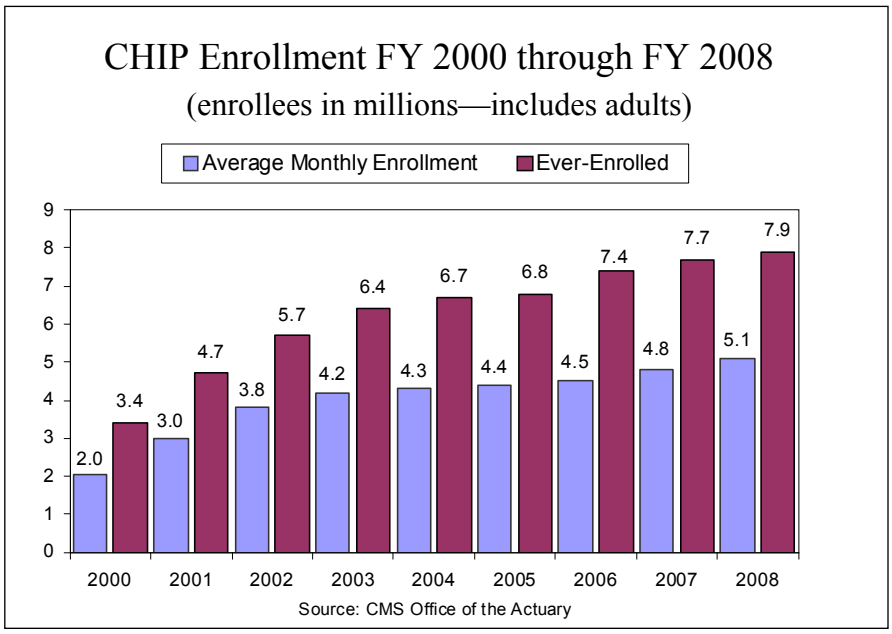
Child Enrollment Contingency Fund: Establishes a contingency fund to alleviate future State funding shortfalls through payments based on efforts to increase enrollment in Medicaid and CHIP.

Performance Bonus Payments: Provides funding for performance bonus payments to States that increase enrollment levels above specified targets to offset the additional costs of increased enrollment.

Optional Coverage of Low-income Pregnant Women under a State Plan Amendment: Allows States to cover low-income pregnant women under a State Plan Amendment rather than under waiver authority.

Coverage of Non-pregnant Childless Adults and Parents: Eliminates new waivers to cover non-pregnant childless adults and phases out existing waiver programs by December 31, 2009, but allows States to transition these populations through Medicaid waivers. Existing waivers that cover parents may continue through FY 2011 with some options to continue through FY 2013, subject to certain statutory conditions and funding limitations.

Promoting Outreach and Enrollment: Provides funding for competitive grants and for a national enrollment campaign to improve enrollment of eligible children in Medicaid and CHIP. Sets aside funds for improving enrollment of Indian children.



Express Lane Eligibility Determination: Allows States to rely on findings from an Express Lane Agency to determine eligibility for Medicaid and CHIP.

Alternative Process for Citizenship Documentation: Creates an alternative process for verifying citizenship and nationality that aims to lessen the administrative burden on States.

Coverage of Legal Immigrant Pregnant Women and Children: Creates a State option to provide coverage under Medicaid and CHIP for otherwise eligible pregnant women and children who are lawfully residing in the United States, without application of a five-year waiting period.

Additional Option to Provide Premium Assistance: Creates a State option to provide premium assistance subsidies for qualified employer-sponsored insurance to all Medicaid and/or CHIP eligible children and parents.

Children's Health Quality Initiative: Establishes several activities that aim to improve measurement of pediatric health quality and child health quality outcomes.

Dental Benefits: Requires that all State CHIP plans provide dental coverage to all beneficiaries.

Mental Health Parity in CHIP: Requires parity of benefits and cost sharing for mental health and substance abuse treatment and medical and surgical services.

Medicaid and CHIP Payment and Access Commission (MACPAC): Creates a commission similar to MedPAC for improving access to care and delivery in the Medicaid and CHIP programs.

Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173)

FY 2009 Shortfall Funding: The Act provided $275 million in funding for States who experienced funding shortfalls in FY 2009.

STATE GRANTS AND DEMONSTRATIONS

(dollars in millions)

	2008	2009	2010	2010 +/- 2009
Current Law Budget Authority:				
CHIP Outreach and Enrollment Grants	--	100	--	-100
CHIP Grants for Prospective Payment System Transition	--	5	--	-5
Medicaid Integrity Program	50	75	75	--
Psychiatric Residential Treatment Demo. and Evaluation	37	49	53	+4
Money Follows the Person (MFP):				
MFP Demonstration	299	349	399	+50
MFP Evaluations and Technical Support	1	1	1	--
Expansion of State Long-Term Care Partnership Program	3	3	3	--
Medicaid Transformation Grants	75	--	--	--
Emergency Services for Undocumented Aliens	250	--	--	--
Ticket to Work Grant Programs	44	46	46	--
Drug Surveys and Reports	5	5	5	--
Total, Current Law B.A.	**764**	**633**	**582**	**-51**
Proposed Law Budget Authority:				
High Risk Pools	--	--	75	+75
Total, Proposed Law B.A.	**--**	**--**	**75**	**75**
Current Law Outlays:				
CHIP Outreach and Enrollment Grants	--	10	23	+13
CHIP Grants for Prospective Payment System Transition	--	3	2	-1
Medicaid Integrity Program	27	75	75	--
Psychiatric Residential Treatment Demo. and Evaluation	--	25	40	+15
Money Follows the Person (MFP):				
MFP Demonstration	12	359	474	+115
MFP Evaluations and Technical Support	1	3	1	-2
Expansion of State Long-Term Care Partnership Program	--	3	3	--
Medicaid Transformation Grants	31	77	39	-38
Emergency Services for Undocumented Aliens	196	133	50	-83
Ticket to Work Grant Programs	56	65	68	+3
Drug Surveys and Reports	2	1	--	-1
High Risk Pools/1/2	23	4	--	-4
Pilot Background Checks	4	3	--	-3
State Pharmacy Assistance Program	2	1	--	-1
Katrina Hurricane Relief	66	96	--	-96
Program of All-Inclusive Care for the Elderly (PACE):				
PACE Rural Site Development Grants	5	2	--	-2
PACE Funds for Outlier Costs/1	--	5	5	--
Alternate Non-Emergency Network Providers	2	32	16	-16
Total, Current Law Outlays	**427**	**897**	**796**	**-101**
Proposed Law Outlays:				
High Risk Pools	--	--	20	+20
Total, Proposed Law Outlays	**--**	**--**	**20**	**20**
Total Net B.A., Proposed Law	**764**	**633**	**657**	**24**
Total Net Outlays, Proposed Law	**427**	**897**	**816**	**-81**

1/ FY 2008 and 2009 outlays are from FY 2007 budget authority.
2/ The Omnibus Appropriations Act, 2009 (P.L. 111-8) appropriated $75 million for State High Risk Pools for FY 2009, which are administered in the Program Management budget.

STATE GRANTS AND DEMONSTRATIONS

The State Grants and Demonstrations budget funds a diverse group of program activities. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), the Deficit Reduction Act of 2005 (DRA), and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added many activities to this area. The President's FY 2010 Budget proposes funding High Risk Pools here.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA) (P.L. 111-3)

Outreach and Enrollment Grants
Section 201 of CHIPRA created Outreach and Enrollment Grants in the Children's Health Insurance Program (CHIP). The Act appropriated $100 million for FY 2009 through FY 2013 for these grants, of which $10 million are set aside for grants to Indian Health Service providers and urban Indian organizations for improving enrollment of Indian children. Another $10 million are set aside for a National Enrollment Campaign to encourage enrollment of eligible children in Medicaid and CHIP.

Grants for Transitioning to a Prospective Payment System
Section 503 provided $5 million for grants to States to help Federally Qualified Health Centers and Rural Health Clinics transition to a Prospective Payment System for CHIP in FY 2009.

DEFICIT REDUCTION ACT (DRA) (P.L. 109-171)

Medicaid Integrity Program
The Medicaid Integrity Program (MIP) was established by section 6034 of the DRA and was implemented in FY 2006. Congress appropriated resources to the MIP as follows: $5 million in FY 2006; $50 million in each of FY 2007 and FY 2008; and, $75 million in FY 2009 and for each year thereafter. HHS has entered into contracts with eligible entities to carry out certain specified activities including reviews, audits, identification of over-payments, education, and technical support to States. These initiatives are highlighted in annual reports which can be found at: http://www.cms.hhs.gov/DeficitReductionAct/021_repcongress.asp.

Home and Community-Based Services Alternatives to Psychiatric Residential Treatment Facilities for Children
The five-year demonstration (FY 2007-FY 2011) authorized by section 6063 of the DRA provided up to 10 States with funds totaling no more than $217 million with the opportunity to provide home and community-based services to individuals under the age of 21 as alternatives to psychiatric residential treatment facilities, including $1 million for evaluation of the program.

Money Follows the Person Demonstration
Section 6071 of the DRA established this demonstration which allows States to work toward sustaining their Medicaid programs while helping individuals achieve independence. States are awarded competitive grants along with an increased Medicaid matching rate for transitioning individuals from an institutional setting to a qualified home or community-based setting. The DRA appropriated $1.75 billion over five years (FY 2007-2011) for this demonstration, with 31 grants committed to States totaling $1.4 billion in FY 2007.

Expansion of State Long-Term Care Partnership Program
The expansion of the State Long-Term Care (LTC) Partnership Program, enacted under section 6021 of the DRA, established authority for all States to implement LTC partnership plans that provide a dollar for dollar disregard of assets or resources equal to the insurance benefit payments on behalf of the individual.

Medicaid Transformation Grants
Established by section 6081 of the DRA, this program provided new grant funds to States for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under Medicaid.

MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT (MMA) (P.L. 108-173)

Federal Reimbursement of Emergency Health Services Furnished To Undocumented Aliens
Section 1011 of the MMA appropriated $250 million per year in FY 2005 through FY 2008 for payments to eligible providers for emergency health services provided to undocumented aliens and other specified non-citizens who are not eligible for Medicaid.

TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT (TWWIIA) (P.L. 106-170)

TWWIIA of 1999 authorized two grant programs designed to assist States in developing services and supports to aid the competitive employment of people with disabilities by extending Medicaid coverage to these individuals. For the Demonstration to Maintain Independence & Employment in section 204 of TWWIAA of 1999,

the authority for payments to be provided by the section expires September 30, 2009. Sec. 203, the Medicaid Infrastructure Grants, continues through FY 2011. The Omnibus Appropriations Act of 2009 further rescinded $21.5 million in unspent funds.

LEGISLATIVE PROPOSAL

Qualified High-Risk Pools

State high-risk health insurance pools target certain individuals who cannot otherwise obtain or afford health insurance in the private market, primarily due to pre-existing health conditions. The Budget proposes $75 million in mandatory funds for FY 2010 to be used towards helping States offer health insurance options for hard-to-insure populations.

(dollars in millions)

	2008	2009	2010	2010 +/- 2009
Discretionary Administration				
Medicare Operations	2,159	2,266	2,364	+98
Federal Administration /2	636	641	698	+56
Survey and Certification	281	293	347	+54
Research	31	30	57	+27
High-Risk Insurance Pools /3	49	--	--	--
Total, Discretionary	**3,157**	**3,230**	**3,466**	**+235**
Mandatory Administration				
Medicare, Medicaid, and SCHIP Extension Act	115	--	--	--
Medicare Improvement Patient and Provider Act	20	183	35	-148
Children's Health Insurance Program Reauthorization Act	--	5	--	-5
State High Risk Pools	--	75	--	-75
American Recovery and Reinvestment Act	--	142	140	-2
Total, Mandatory	**135**	**405**	**175**	**-230**
Reimbursable Administration (non-add) /4	*572*	*209*	*430*	*+221*
Subtotal, Discretionary and Mandatory	**3,292**	**3,635**	**3,641**	**+6**
Proposed Law Mandatory User Fee				
Survey and Cert. Revisit and Recert. User Fees	--	--	9	+9
Total, Proposed Law Mandatory	**--**	**--**	**9**	**+9**
FTE /5	4,483	4,461	4,717	+256

1/ Numbers may not add due to rounding

2/ FY 2008 Federal Administration level includes $5 million from the FY 2008 Supplemental Appropriation.

3/ State High Risk Pools recategorized as mandatory Program Management in 2009 and transferred to the State Grants and Demonstrations account as mandatory funding in 2010.

4/ Includes Clinical Laboratory Improvement Amendments of 1988, sale of research data, coordination of benefits for the Medicare prescription drug program, MA/prescription drug program information campaign, and recovery audit contracts. These amounts do not affect CMS's program level because the activities they fund are fully reimbursed.

5/ FTE totals include HCFAC and State Grants funded FTEs. CMS will fund the following FTEs from the HCFAC and State Grants accounts: FY 2008 - 164 FTEs; FY 2009 - 183 FTEs; FY 2010 - 215 FTEs. CMS also plans to fund 50 FTEs in FY 2009 and 100 FTEs in FY 2010 to implement the Recovery Act.

PROGRAM MANAGEMENT

The FY 2010 discretionary budget request for CMS Program Management is $3.5 billion, an increase of $235 million over FY 2009. The Budget includes mandatory proposed user fees on health care facilities for recertification and revisit surveys. With the funding requested for FY 2010, CMS will achieve its priority goals: implement Medicare contracting reform; sustain beneficiary education efforts; increase survey frequencies; make targeted investments in information technology (IT); administer new legislation; augment its research agenda; and administer basic operations.

Medicare Contracting Reform Transition Schedule

Projected Award Date	Medicare Administrative Contractor to be Transitioned	Number of Contractors
CY 2006	Durable Medical Equipment	4
CY 2007	Part A/B	1
CY 2008	Part A/B - Cycle 1	7
CY 2009	Part A/B - Cycle 2	7

BUDGET ACCOUNT SUMMARIES

Medicare Operations: The Medicare Operations budget request is $2.4 billion, an increase of $98.1 million, or 4.3 percent, above FY 2009. The bulk of the CMS Program Management budget, or 68 percent, is spent on Medicare Operations. The Medicare Operations budget funds mission-critical contractor and IT activities necessary to administer the Medicare program and implement activities required by legislation. Top priority activities for FY 2010 include:

Contracting Reform: The Budget requests $65.6 million to implement contracting reform, a reduction of $43.3 million below FY 2009. CMS is winding down transitions and on track to complete contracting reform before the 2011 target set in the MMA.

Contracting reform will transform Medicare claims processing from 40 cost-based contracts to 15 performance-based, competitive contracts (plus four specialty contractors). In 2009, CMS awarded the last of the 19 competitive Medicare Administrative Contracts (MACs). In FY 2010, CMS plans to finish transferring the remaining Medicare claims workloads to these new contractors.

Contracting reform is projected to generate significant administrative savings to the government and providers by reducing the cost of processing Medicare claims, and yield $3.1 billion in Trust Fund savings over the next five years (FY 2009 – FY 2013) through more accurate and appropriate payments.

MIPPA Implementation: The Budget requests $81.6 million to implement the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA). This funding will supplement the appropriation provided in the mandatory legislation for implementation. The complexity and volume of provisions in MIPPA require additional administrative investment. Specifically, the request will allow CMS to implement ESRD pay-for-performance.

Ongoing Contractor Operations and Support: About half, or $1.049 billon, of the FY 2010 Medicare Operations request supports ongoing contractor operations, 1.5 percent above the FY 2009 level. Contractors will process an estimated 1.2 billion fee-for-service claims in FY 2010, a 2.6 percent increase over FY 2009.

Beneficiary Education and Outreach: The Budget includes $315.6 million for mandated and other beneficiary education and outreach activities through the National Medicare & You Education Program (described in a later section).

Healthcare Integrated General Ledger and Accounting System (HIGLAS): The Budget requests $161.0 million for HIGLAS, a state-of-the-art accounting system for CMS. HIGLAS is an important fiscal and program integrity tool, necessary to achieve a clean statutorily-required audit opinion and process 100 percent of CMS payments through a single system by 2012. Of the HIGLAS total, $125.3 million supports ongoing HIGLAS operations at 23 contractors that will be "operational" at the end of

FY 2010. The remaining $35.7 million will be used to develop additional HIGLAS functionalities, such as incorporating Medicare Part C and Part D accounting transactions. HIGLAS has already yielded significant savings and efficiencies through more rapid recovery collections, resulting in a projected $390 million total interest earned through FY 2011.

IT Systems and Other Supporting Activities: The Budget includes $691.4 million for other IT systems and support. This investment includes funding for systems to manage and administer Medicare Advantage and the new Part D benefit, CMS's data center and telecommunications infrastructure, and other funding for HIPAA, qualified independent contractor appeals, and the CFO audit.

This amount also includes $62.5 million to begin converting to ICD-10, a classification system of diseases, injuries, and medical conditions developed by the World Health Organization. The ICD-10 code set, currently used by much of the industrialized world, will make it easier to determine if a claim was appropriately billed, provide more specific data necessary for value-based purchasing, and prevent fraud and abuse. Regulations promulgated on January 2009 require CMS and other insurers to convert to ICD-10 by October 1, 2013.

Federal Administration: For FY 2010, the President's Budget requests $697.8 million for CMS Federal administrative costs, a $56.4 million or 9 percent increase over FY 2009. Of this total, $565.9 million will support a Full Time Equivalent (FTE) complement of 4,276, an increase of 159 FTE over 2009. This staffing increase will allow timely implementation of numerous program changes enacted in recent reconciliation bills, and position CMS for health care and entitlement reform.

Survey and Certification: The FY 2010 Survey and Certification budget request is $347 million, a $54 million, or 18 percent, increase over FY 2009. At this funding level, CMS will establish more frequent surveys of health facilities. Survey frequencies have steadily declined in recent years, potentially compromising the safety and quality of care provided to beneficiaries.

All facilities participating in the Medicare and Medicaid programs must undergo an inspection when entering the program, and on a regular basis thereafter, to ensure compliance with Federal health, safety, and program standards. CMS contracts with State agencies to conduct these inspections.

States will inspect long-term care facilities and home health agencies at their statutorily mandated frequencies. Survey frequencies for all other facility types will increase to no less than once every six years (see table this page). This funding is essential to improve the quality of care in nursing homes through rigorous survey and enforcement processes and ensure adequate oversight of all other provider

Performance Highlight

The prevalence of physical restraints is an accepted indicator of quality of care in nursing homes, and their use has declined dramatically from the 1996 baseline of 17.2 percent of residents. CMS exceeded its FY 2008 target, achieving an historic low level of 4 percent. This recent success can be attributed to CMS's major quality initiatives including CMS annual surveys, efforts of the Quality Improvement Organizations, and the national campaign entitled *Advancing Excellence in Nursing Homes*. The FY 2010 target is 3.8 percent.

SURVEY AND CERTIFICATION FREQUENCIES

Type of Facility	2008	2009	2010
Long-Term Care Facilities*	Every Year	Every Year	Every Year
Home Health Agencies*	Every 3 Years	Every 3 Years	Every 3 Years
Accredited Hospitals	1% Per Year	1% Per Year	2% Per Year
Non-Accredited Hospitals	Every 5 Years	Every 5 Years	Every 3 Years
Organ Transplant Facilities	Every 3 Years	Every 3 Years	Every 3 Years
ESRD Facilities	Every 4 Years	Every 4.6 Years	Every 3 Years
Hospices, Outpatient Physical Therapy, Outpatient Rehabilitation, Portable X-Rays, Rural Health Clinics, and Ambulatory Surgical Centers	Every 10 Years	Every 11.5 Years	Every 6 Years

*Legislatively Mandated

types, where quality of care concerns have been increasing.

CMS expects States to complete 25,300 certifications and over 58,000 complaint visits in FY 2010, an increase of approximately 13,000 visits over the FY 2009 level. Between FY 2003 and FY 2010, the number of Medicare-certified facilities increased by 19 percent. The FY 2010 Budget includes $9.4 million from two user fees to finance survey and certification activities. Permanent authority is requested for both fees, to ensure that survey and certification activities have an adequate and stable funding supply in future years.

Revisit User Fee: CMS would charge revisit user fees to health care facilities cited for deficiencies during initial certification, recertification or substantiated complaint surveys. These facilities would finance the full costs associated with revisit surveys to ensure corrective actions have been implemented. This fee will build greater accountability into the survey and certification program and create an incentive for facilities to correct deficiencies and ensure quality of care. This fee is expected to provide $9.4 million to support this survey and certification activities in FY 2010.

Recertification User Fee: CMS would charge user fees to all participating health care facilities at the time of their periodic recertification surveys. The surveyed health care facilities would partially finance the costs associated with these surveys, with fees phased-in over three years to a level equal to 33 percent of costs, on average. Charging for program participation surveys is consistent with the fee-based approach for other services, and reflects the fact that recertification gives providers the opportunity to continue to participate in Medicare. Due to the time required to draft a regulation and implement the fee, no funds will be collected in FY 2010.

Research, Demonstrations and Evaluation: The FY 2010 Research, Demonstrations and Evaluation budget request is $57.0 million, a $27.0 million increase over FY 2009.

Of this total, $30 million will be dedicated to expanding the Medicare and Medicaid research agenda. CMS will develop new demonstration and pilot projects that will focus on payment reforms such as better aligning provider payments with costs, providing higher quality care at a lower cost, and improving beneficiary education. Research projects undertaken with this new funding will lay the groundwork for long-term reform of the health care system.

The Medicare Current Beneficiary Survey (MCBS) is fully funded at $14.8 million within the request. The MCBS, a continuous, multi-purpose survey that represents the Medicare population, aids CMS in monitoring and evaluating the Medicare program. The Budget also includes $2.5 million to fund Real Choice Systems Change grants. The grants will assist States in designing and implementing improvements to community-based support systems that enable people with disabilities and long-term illnesses to live and participate in the community.

The remaining $9.7 million supports ongoing basic research, such as monitoring prospective payment systems and evaluating demonstrations and pilots.

OTHER CMS ADMINISTRATIVE ACTIVITIES

The National Medicare & You Education Program (NMEP): The total FY 2010 program level for NMEP is $400.4 million, a decrease of $2.0 million from the FY 2009 level. The NMEP program level includes funding from Program Management, Medicare Advantage/Prescription Drug Program user fees, and QIOs. Beneficiary education remains a top priority for CMS, as recent enhancements to Medicare have given beneficiaries more responsibility for making their own health care decisions.

National Medicare & You Education Program
(dollars in millions)

Activity	2009	2010
Beneficiary Materials (e.g., Handbook).....	48.9	54.1
1-800-MEDICARE Toll Free Line/1.....	267.2	265.4
Internet.....	17.1	20.6
Community-Based Outreach /2.....	54.9	43.3
Program Support Services /3.....	14.3	17.1
Total, NMEP Program Level/4.....	**402.4**	**400.4**

/1 Includes funding previously allotted to Medicare contractors for claims-related inquiries
/2 Includes State Health Insurance and Assistance Program (SHIP) grants
/3 Includes multi-media campaign and consumer research
/4 Includes funding from Program Management, user fee, QIO, and the Medicare Improvements for Patients and Providers Act of 2008.

Of the total, $265.4 million, or 66 percent – supports 1-800-MEDICARE, which provides customer service in English and Spanish. Compared to the FY 2009 level, the call center request is $1.8 million lower. CMS anticipates approximately 28.1 million calls in FY 2010 and aims to increase call center efficiencies.

The remaining NMEP funding supports other important beneficiary education activities. About $54.1 million will be used to distribute more than 44 million Medicare & You handbooks, approximately 1.1 million more than in FY 2009. Another $20.6 million will support 460 million page views at www.medicare.gov, 13 million over FY 2009. As one-on-one counseling is the best method to help beneficiaries navigate their health plan options, the Budget allocates $40.0 million for State Health Insurance Assistance Program (SHIP) grants. More than 12,000 counselors in over 1,300 community based organizations will provide one-on-one assistance to beneficiaries on complex Medicare-related topics. Finally, NMEP includes $17.1 million, an increase of $2.8 million, for a multimedia campaign, including paid advertising and a mobile office tour.

ADMINISTRATION FOR CHILDREN AND FAMILIES

(dollars in millions)

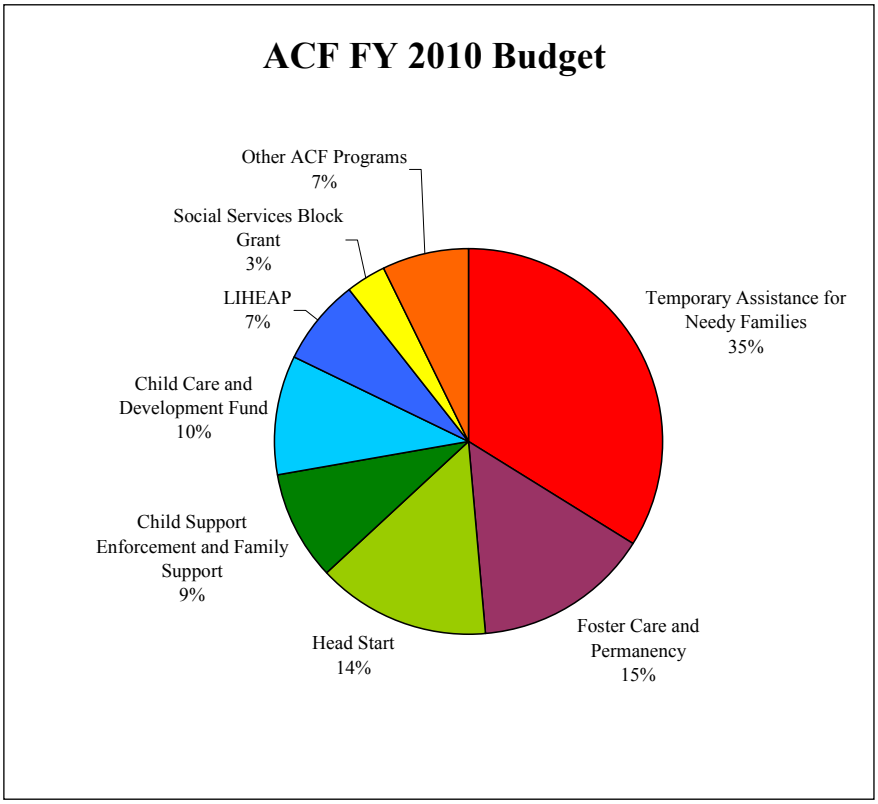
	2008	2009	2010	2010 +/- 2009
Discretionary /1				
Program Level	14,382	22,423	15,651	-6,772
Budget Authority	14,322	22,375	15,591	-6,784
Entitlement /2				
Budget Authority	33,899	38,657	34,648	-4,009
Total, ACF Budget Authority	**48,221**	**61,032**	**50,239**	**-10,793**
Total, ACF Budget Authority, Excluding Recovery Act	**48,221**	**50,067**	**48,961**	**-1,106**

1/ Includes Recovery Act funding of $5.1 billion in FY 2009.

2/ Includes Recovery Act funding of $5.8 billion in FY 2009 and $1.3 billion in FY 2010.

The Administration for Children and Families promotes the economic and social well-being of children, youth, families, and communities, focusing particular attention on vulnerable populations, such as children in low-income families, refugees, Native Americans, and people with developmental disabilities.

The FY 2010 Budget request for the Administration for Children and Families (ACF) is $49 billion, a net decrease of $1.1 billion below the FY 2009 Omnibus, excluding Recovery Act funding. ACF administers over 60 programs to fulfill its mission of serving America's children and families. The discretionary Budget includes additional funding for Head Start, Refugee programs, and a new child welfare initiative. The mandatory Budget includes $17.1 billion for Temporary Assistance for Needy Families, $7.3 billion for Foster Care and related programs, $4.6 billion for Child Support Enforcement and Family Support, and $124 million for a new program to provide funds to States for evidence-based home visitation programs for low-income families.



ADMINISTRATION FOR CHILDREN AND FAMILIES: DISCRETIONARY SPENDING

The Administration For Children and Families
Department of Health and Human Services

(dollars in millions)

	2008	2009 ARRA*	2009 Omnibus	2010	2010 +/- Omnibus
Zero to Five Initiative					
Head Start**	6,878	2,100	7,113	7,235	+122
Early Head Start (non add)	*688*	*1,100*	*710*	*721*	*+11*
Child Care & Development Block Grant (discretionary)	2,062	2,000	2,127	2,127	--
Other Assistance for Children and Youth					--
Teenage Pregnancy Prevention					--
Community Based Grants (discretionary)	109	--	95	110	+15
PHS Evaluation Funds	5	--	4	4	--
State Grants (mandatory)	50	--	38	50	+13
Subtotal Teenage Pregnancy	163	--	137	164	+28
Child Welfare Programs	327	--	327	347	+20
Innovative Approaches to Foster Care (non add)	--	--	--	*20*	*+20*
Adoption Incentives	4	--	37	40	+3
Adoptions, Children's Health Act	12	--	13	13	--
Child Abuse Programs	105	--	110	108	-2
Home Visitation (non add)	*10*	--	*14*	*14*	--
Promoting Safe and Stable Families (discretionary)	63	--	63	63	--
Mentoring Children of Prisoners	49	--	49	49	--
Runaway and Homeless Youth Programs	113	--	115	115	--
Independent Living (Vouchers)	45	--	45	45	--
Subtotal, Children and Youth	9,823	4,100	10,136	10,306	+170
Assistance to Other Vulnerable Groups					--
LIHEAP					--
State Formula Grants	1,980	--	4,510	2,410	-2,100
Emergency Contingency Fund	590	--	590	790	+200
Legislative Trigger (Mandatory)	--	--	--	***	***
Subtotal, LIHEAP	2,570	--	5,100	3,200	-1,900
Refugee Programs					
Transitional and Medical Services	296	--	282	337	+55
Unaccompanied Alien Children	133	--	123	176	+52
Other Refugee Programs	227	--	228	228	--
Subtotal, Refugee Programs	656	--	633	741	+107
Community Services Programs	722	1,000	775	765	-10
Strengthening Communities Fund	--	50	--	50	+50
Compassion Capital Fund (CCF)	53	--	48	--	-48
Center for Faith Based and Community Initiatives	1	--	1	1	--
Developmental Disabilities	180	--	184	184	--
Disaster Human Services Case Management	--	--	--	2	+2
Native Americans	46	--	47	47	--
Violent Crime Reduction	125	--	131	131	--
Social Services Research & Demonstration	15	--	14	--	-14
PHS Evaluation Funds (non add)	*6*	--	*6*	*6*	--
Federal Administration	184	--	197	218	+21
Total, Program Level	**14,382**	**5,150**	**17,273**	**15,651**	**-1,622**
Less Funds From Other Sources					
Mandatory Teen Pregnancy Prevention Funding	50	--	38	50	+13
PHS Evaluation Funds	11	--	10	10	--
Total Discretionary Budget Authority	**14,322**	**5,150**	**17,225**	**15,591**	**-1,634**
FTE (including those financed with mandatory funds)	1,283	--	1,328	1,479	151

* American Recovery and Reinvestment Act of 2009 (Recovery Act).....

** The 2009 Omnibus funding level does not include $1.4 billion appropriated in FY 2008 but not available until FY 2009.

*'** Release amounts determined by FY 2009 energy price increases. Based on probabilistic scoring $450 million is shown for FY 2010.

ADMINISTRATION FOR CHILDREN AND FAMILIES: DISCRETIONARY SPENDING

The FY 2010 discretionary Budget request for ACF is $15.6 billion, a decrease of $1.6 billion below FY 2009. Children's programs are prioritized with major increases for Head Start and new initiatives to prevent teenage pregnancy and reduce long-term foster care placements. Included in this Budget request is $3.2 billion for LIHEAP, a reduction of $1.9 billion but the highest LIHEAP funding level for any year except for the most recent. A legislative proposal would provide additional mandatory LIHEAP funding if energy prices increase significantly.

ZERO TO FIVE INITIATIVE

The Budget makes a down payment on the President's Zero to Five Initiative, a comprehensive early childhood education plan to support young children and their families. Within ACF, this initiative includes a commitment to affordable, high quality child care, to expanding Head Start and Early Head Start, and to launching a new Home Visitation program, described in the ACF Mandatory section of the Budget in Brief.

Helping Children Get the Best Start: The FY 2010 Budget request for Head Start is $7.2 billion, an increase of $122 million over FY 2009. Including one-time funding from the Recovery Act, Head Start received a total of $9.2 billion in FY 2009, which will provide services for an estimated 978,000 children from birth to age five, an increase of approximately 70,000 over FY 2008. The FY 2010 increase will ensure that the portion of grantees' FY 2009 cost-of-living adjustment paid for with Recovery Act monies remains available to grantees within their base funding in FY 2010. The FY 2010 increase, combined with Recovery Act resources, enables Head Start to sustain the FY 2009 increase in children served in FY 2010. In support of the President's emphasis on the early care and education of infants, approximately 115,000 infants and toddlers, nearly twice as many as in FY 2008, will have access to Early Head Start services in FY 2009 and FY 2010.

Child Care: The discretionary Budget includes $2.1 billion for the Child Care and Development Block Grant (CCDBG), the same as FY 2009. These resources support child care subsidies to low-income families who are working or attending training or education and other activities that improve the quality and availability of child care. The Recovery Act also provided $2 billion to expand the availability of child care and improve its quality. These funds will serve an estimated 200,000 to 220,000 additional children and families over two years, with maximum flexibility for States.

The Budget requests a total of $5 billion for child care through the Child Care and Development Fund, which includes CCDBG ($2.1 billion) and $2.9 billion in mandatory funds for the Child Care Entitlement to States, sufficient to provide assistance to an estimated 1.6 million children each month. Combined Federal and related State child care funding provides child care assistance to 2.6 million children per month.

PROVIDING ASSISTANCE FOR CHILDREN AND YOUTH

Teen Pregnancy Prevention: The ACF Budget includes $110 million to support community-based efforts to reduce teen pregnancy. The majority of funds for this effort will support programs using models whose effectiveness has been demonstrated through rigorous evaluation. A smaller portion of funds will be available to develop and test promising teen prevention programs. Previous evaluations indicate that the most positive results come from high intensity youth development programs that provide a range of services in addition to comprehensive sex education, such as after school activities, academic support, or service learning.

The Centers for Disease Control and Prevention will increase its support for national organizations and State teen pregnancy prevention coalitions to select, implement, and evaluate science-based programs to prevent

Recovery Act

The Recovery Act provides $2.1 billion for Head Start, $1.1 billion of which is specifically for Early Head Start expansion. This historic increase will allow Head Start and Early Head Start to serve approximately 70,000 additional children, 55,000 of whom are infants and toddlers. The Head Start program helps low-income children arrive at school ready to learn by enhancing their social and cognitive development through the provision of educational, health, nutritional, social and other services. The program has served more than 25 million children since it began in 1965.

teen pregnancy. ACF evaluation funds ($4 million annually) also will continue to be used to test a range of teen pregnancy prevention programs.

The Budget redirects funding from ACF's abstinence-only education programs to evidenced based and promising teen pregnancy prevention programs as described above. The Administration will not seek reauthorization for the mandatory State Abstinence Education formula grants when they expire in June of 2009. The Budget instead requests $50 million in mandatory funds for State, Tribal, and Territory teen pregnancy prevention efforts.

Child Welfare: The Budget requests $347 million to support State public welfare agencies to protect and promote the well-being of all children. These activities include preventing abuse and neglect; supporting at-risk families through services to keep children at home where appropriate; securing alternative placements (e.g., foster care, adoption) for children who must be removed from their homes; and reunification services when it is appropriate for children to return home to their families.

Innovative Approaches to Foster Care: The Budget request includes $20 million to fund projects that aim to improve outcomes for children in foster care. This program will provide upfront funding for the purpose of implementing and sustaining evidence-based practice improvements. Grantees demonstrating an improvement in child and family outcomes will be eligible to receive bonus funding.

Adoption Incentives: States that successfully increase the number of children adopted from their public foster care systems receive bonus payments from ACF. The Budget requests $40 million for these bonuses, an increase of $3 million over FY 2009, to fully cover anticipated State bonus payment levels. States receive bonus payments for adoptions completed in the previous year. The Fostering Connections to Success and Increasing Adoptions Act of 2008 raised bonus payments for adoption of special needs and older children and made other program improvements. After remaining unchanged for several years, data indicates a 5 percent increase (to 54,000) in the number of adoptions between FY 2007 and FY 2008.

Child Abuse Prevention: The Budget request includes $108 million, the same level as FY 2009 excluding one-time congressional projects. Funds support grants to States through the Child Abuse Prevention and Treatment Act to strengthen the State's child protective service systems, including their investigation of abuse, training for child protection workers, and programs to prevent and treat child abuse and neglect. Funds also support a continuum of prevention efforts, including community-based activities, research on child maltreatment, and training and technical assistance.

Promoting Safe and Stable Families: To continue supporting States' efforts to coordinate their family preservation services, the FY 2010 Budget maintains funding at $443 million for the Promoting Safe and Stable Families program, of which $63 million is financed through discretionary resources. Funds support community-based activities to promote parental competencies, time-limited reunification services, and adoption promotion and support services.

Other Programs for Children and Youth: The Budget maintains funding at $49 million for the Mentoring Children of Prisoners program to provide grants to eligible entities that support one-on-one mentoring for children of incarcerated parents and those recently released from prison. The Budget also includes $115 million for Runaway and Homeless Youth programs, the same as FY 2009, to make grants to public and private organizations that establish and operate shelters for youth, offer supportive services, provide street-based outreach, and operate Maternity Group Homes. To continue to provide post-secondary educational assistance to foster care youth ages 16 to 21, the Budget maintains funding at the FY 2009 level of $45 million for the Independent Living Education and Training Vouchers programs, which provides up to $5,000 per participant for expenses like tuition, books, and other fees.

ASSISTANCE FOR OTHER VULNERABLE GROUPS

Low Income Home Energy Assistance: The Budget requests $3.2 billion for the LIHEAP program to help low-income households heat and cool their homes. The Budget request is larger than any previous year, except for the most recent, when the nation was threatened with an unprecedented increase in energy costs. Energy prices are volatile, making it difficult to match funding to need. For this reason, the Budget includes a legislative proposal to provide additional mandatory LIHEAP funding if energy prices increase significantly.

Under the Administration's preliminary design, the legislative proposal would trigger additional funds when oil and natural gas prices increase by at least

15 percent or electricity prices increase by at least 10 percent. Price increases would be measured by comparing quarterly prices with prices from the same quarter of the previous year. The amount of funds released would be determined by the percent increase in prices, and the size of the prior year's formula grant appropriation. For example, if fourth quarter 2009 energy prices exceed last year's peak prices by just two percent (oil at $126 per barrel) this legislative proposal could bring total LIHEAP funding to $5.1 billion, the same as the FY 2009 level. The Administration will work with Congress to develop a final trigger design within the resources provided in the Budget.

The Administration is committed to more efficient use of energy. The Recovery Act provided $5 billion to the Energy Department's Weatherization Assistance Program, sufficient to permanently lower home energy bills for hundreds of thousands of low-income homes.

Refugees: The Office of Refugee Resettlement (ORR) provides services to newly arrived refugees and other entrants, unaccompanied alien children and victims of trafficking and torture. Major activities include the provision of time-limited (transitional) cash and medical assistance, English instruction, and job-training to help new arrivals achieve economic self-sufficiency. Care is also provided to unaccompanied alien children (UACs) who are apprehended in the U.S. by the Department of Homeland Security, or other law enforcement. ACF retains custody of these children until they can be released to relatives or sponsors or their relief claims under U.S. immigration law are resolved.

Strengthening Communities

The new Strengthening Communities Fund will build the capacity of nonprofit organizations to address the needs of distressed communities. Capacity building activities are designed to increase an organization's sustainability and effectiveness, enhance its ability to provide social services, and create collaborations to better serve those in need.

The Budget requests $741 million for these activities, an increase of $107 million over FY 2009. The Budget includes an additional $55 million primarily to reimburse states for the transitional and medical costs of helping newly arrived refugees achieve self-sufficiency. State costs are increasing as refugees take longer to achieve self-sufficiency in the current economy. An additional $52 million is also included to address legislative changes to the UAC program, which are anticipated to increase the number of children in ACF custody. The recently enacted William Wilberforce Trafficking Victims Protection Reauthorization gives ACF custody of certain UACs from contiguous countries (Mexico and Canada) who are apprehended crossing the Border. In the past, UACs from Mexico were re-patriated without coming into ACF's custody.

Performance Highlight

The percent of unaccompanied alien children that received medical screening or examination within 48 hours of admission to Office of Refugee Resettlement facilities increased from 75.5 percent in FY 2006 to 88.9 percent in FY 2008.

Community Services Programs: To support State efforts to reduce poverty and assist low-income residents, the FY 2010 Budget request includes $765 million for Community Services Programs, a decrease of $10 million below FY 2009. Funding is maintained for the Community Services Block Grant and for all other Community Service Programs except for the Rural Community Facilities Program ($10 million in FY 2009), which provides grants to communities to develop and design water treatment facilities. Maintaining a separate rural water facilities program in ACF is inefficient. Both the Environmental Protection Agency and the U.S. Department of Agriculture provide far larger amounts of funding for financing water treatment programs.

Strengthening Communities Fund: The Budget provides $50 million in FY 2010 for the Strengthening Communities Fund (SCF), a new effort created through the Recovery Act and funded at $50 million in FY 2009. Funds will be used to build the capacity of faith-based and community-based non-profits to serve low-income and disadvantaged populations. Grant activities will help these organizations expand service delivery, increase community access to public benefits, and help low and moderate-income people secure and retain employment. The SCF replaces the Compassion Capital Fund.

Developmental Disabilities: The Budget requests $184 million, the same as FY 2009, to help ensure that individuals with developmental disabilities have opportunities to contribute to and participate in all

facets of community life and can access culturally competent support services that are consumer-centered. These funds are also used to protect the legal and human rights of individuals with disabilities and to increase their voter participation.

Disaster Human Services Case Management: Hurricane Katrina demonstrated the need for case management to assist individuals affected by disasters regain self-sufficiency. To determine how to create a model disaster case management program, ACF conducted a pilot project during the 2008 Hurricanes Gustav and Ike. More than 5,500 individuals enrolled and received case management services faster than ever before. The FY 2010 Budget includes $2 million to further address this issue.

Native Americans: The Administration for Native Americans promotes economic self-sufficiency and preservation of Native American languages and culture. Grants are provided to Tribes, other Native American communities, Native Hawaiians, and other Native Pacific Islanders organizations. Funds can be used for a range of projects including jobs creation, increasing the capacity of tribal governments, establishment of local court systems, enactment of new codes and environmental ordinances and improved control of natural resources. The Budget requests $47 million, the same as FY 2009.

Violent Crime Reduction: The FY 2010 Budget maintains funding at the FY 2009 level of $131 million for programs that prevent family violence, offer shelter for victims of family violence and their dependents, and provide intervention services for families in abusive situations. Funds also support the National Domestic Violence Hotline, a toll-free telephone hotline that operates 24 hours a day to provide information and assistance to victims of domestic violence.

OTHER ACF PROGRAMS

Research: In addition to the evaluation of teen pregnancy prevention ($4 million), the Budget includes $6 million for Social Services Research and Development. These funds support investigation into critical areas, such as the best ways for low-income families to become economically self-sufficient.

Federal Administration: The Budget requests $218 million for staff salaries, and other necessary administrative activities, an increase of $21 million over FY 2009. Additional funds will primarily be used to meet additional program requirements from new legislation. For example, the Head Start Reauthorization made significant changes to the program, including creating new competition requirements for poor performing grantees. The Fostering Connections to Success and Increasing Adoptions Act creates a new Kinship Guardianship program and allows Federally-recognized Tribes to run their own Foster Care and Adoption Assistance programs, both of which required significant additional staff. The William Wilberforce Trafficking Victims Protection Reauthorization includes increased monitoring requirements for the Trafficking and UAC programs.

ADMINISTRATION FOR CHILDREN AND FAMILIES: ENTITLEMENT SPENDING

(dollars in millions)

	2008	2009	2010	2010 +/- 2009
Current Law B.A.:				
Temporary Assistance for Needy Families	17,059	17,059	17,059	--
Recovery Act TANF Supplemental Grants (non-add) /1	--	--	*319*	*+319*
Contingency Fund /2	--	--	--	--
Recovery Act Emergency Contingency Fund /3	--	5,000	--	-5,000
Child Care Entitlement to States	2,917	2,917	2,917	--
Child Support Enforcement and Family Support (net)	4,273	4,317	4,572	+255
Recovery Act Child Support Enforcement (non-add)	--	*426*	*590*	*+164*
Foster Care and Permanency	6,877	7,188	7,335	+147
Recovery Act Foster Care and Permanency (non-add) /4	--	*389*	*369*	*-20*
Children's Research and Technical Asst. (net)	58	58	58	--
Promoting Safe and Stable Families (mandatory only) /5	365	380	380	--
Social Services Block Grant /6	2,300	1,700	1,700	--
Abstinence Education	50	38	--	-38
Total, Current Law B.A.	**33,899**	**38,657**	**34,021**	**-4,636**
Proposed Law B.A.:				
Child Support Enforcement and Family Support (net)	--	--	3	+3
Teen Pregnancy Prevention /7	--	--	50	+50
Home Visitation /8	--	--	124	+124
LIHEAP /9	--	--	450	+450
Proposed Law B.A.	**--**	**--**	**627**	**+627**
Total, Proposed Law B.A.	**33,899**	**38,657**	**34,648**	**-4,009**
Total, Proposed Law B.A. Excluding Recovery Act	**33,899**	**32,842**	**33,370**	**+528**

1/ The American Recovery and Reinvestment Act of 2009 (Recovery Act) extended the TANF Supplemental Grants through FY 2010.
2/ In FY 2006, the Deficit Reduction Act of 2005 extended the availability of unobligated Contingency Fund balances through FY 2010. The FY 2009 beginning balance was $1.3 billion. ACF estimates that at the end of FY 2009 the fund will be exhausted.
3/ The Recovery Act established a pre-appropriated $5 billion TANF Emergency Contingency Fund to address rising costs related to basic assistance and other related services. Unobligated FY 2009 balances are carried forward to FY 2010.
4/ The Recovery Act provision increasing the FMAP rate is effective FY 2009 through the first quarter of FY 2011. FY 2010 budget authority does not reflect these additional three months in FY 2011.
5/ Beginning in FY 2009, the Fostering Connections to Success and Increasing Adoptions Act of 2008 provides $15 million per year for Family Connection Grants.
6/ The FY 2008 Supplemental Budget included $600 million for SSBG to help States affected by Presidentially declared major disasters in 2008.
7/ The FY 2010 Budget assumes that the mandatory abstinence education will not be reauthorized and a newly authorized teen pregnancy prevention initiative is proposed. See ACF Discretionary Programs Section for further explanation.
8/ The President's Budget includes a new mandatory program for Home Visitation that assumes an increase in budget authority and resulting outlays over ten years.
9/ The President's Budget includes a new mandatory funding trigger for LIHEAP. See ACF Discretionary Programs Section for further explanation.

Note: ACF Entitlement Spending in outlays is displayed on the ACF Entitlement - Outlays Overview table, found at the conclusion of this chapter.

ADMINISTRATION FOR CHILDREN AND FAMILIES: ENTITLEMENT SPENDING

The FY 2010 Budget request for ACF Entitlements is $34.3 billion, a net increase of $672 million from the FY 2009 funding level. ACF serves the Nation's most vulnerable populations through entitlement programs such as Temporary Assistance for Needy Families, the Child Care Entitlement to States, Child Support Enforcement, Foster Care, Adoption Assistance, Independent Living, Guardianship Assistance, and Promoting Safe and Stable Families.

The increase in budget authority for FY 2010 is due to implementation of provisions from the American Recovery and Reinvestment Act of 2009 (Recovery Act) (P.L. 111-5) and the Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351), as well as proposals for mandatory Home Visitation, Teen Pregnancy Prevention, and LIHEAP programs.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

On February 8, 2006, the Deficit Reduction Act of 2005 (DRA) (P.L. 109-171) reauthorized TANF through FY 2010. TANF provides approximately $17.1 billion annually to States, Territories, and eligible Tribes to support low-income working families.

States have enormous flexibility under TANF to determine their own eligibility criteria, benefit levels, and types of services and benefits available to TANF recipients. In addition, States may transfer up to a combined 30 percent of their TANF funding to the Child Care and Development Fund (CCDF) and Social Services Block Grant (SSBG), with not more than 10 percent transferred to SSBG.

Since welfare reform was enacted through the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193), States are spending less on cash assistance and more on education and training, child care, and other work supports to help families achieve self-sufficiency. In 1998, States spent 63 percent of combined State and Federal funds on cash assistance, compared to 34 percent in FY 2007.

The economic crisis has put an enormous pressure on low-income working families and TANF. The Recovery Act made several temporary changes to the TANF program to help States facing rising expenditures for TANF and other low-income families. The law created a new two-year, $5 billion emergency contingency fund for states facing increased spending on cash assistance and other related services for low-income families. It also extended the TANF Supplemental Grants through FY 2010, temporarily allows certain adjustments to the caseload reduction credit, and permanently expands use of TANF carry-over funds.

CHILD CARE ENTITLEMENT TO STATES (CCES)

The FY 2010 Budget includes $2.9 billion for the CCES, a component of the Child Care and Development Fund (CCDF). CCES is composed of mandatory and matching funds. Two percent of the mandatory entitlement funds are reserved for eligible Indian Tribes and Tribal organizations. The program requires States to spend at least 70 percent of CCES on families receiving TANF, transitioning from TANF, or at risk of becoming eligible for TANF. States must also spend a minimum of four percent of all child care funds to improve the quality and availability of healthy and safe child care for all families.

Child Care Performance: ACF continues its efforts to improve the quality of child care providers. In CY 2007, CCDF successfully encouraged 32 States to implement early learning guidelines linked to the education and training of caregivers, preschool teachers, and

Recovery Act

- Creates a temporary $5 billion TANF emergency contingency fund available to States, Tribes, and Territories to help pay for increased expenditures in cash assistance, non-recurrent short-term benefits, and subsidized employment.
- Extends TANF Supplemental Grants through FY 2010.
- Provides an estimated $806 million to States for a temporary 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP) rate used to determine the Federal match for maintenance payments for Foster Care, Adoption Assistance, and Kinship Guardianship.
- Temporarily allows States to use Federal child support incentive payments as their State share of expenditures eligible for Federal match.

administrators. This performance exceeds the CY 2007 target of 28 States.

CHILD SUPPORT ENFORCEMENT (CSE) AND FAMILY SUPPORT PROGRAMS

CSE is a joint Federal, State, Tribal, and local partnership that seeks to ensure financial and emotional support for children from both parents by locating non-custodial parents, establishing paternity, and establishing and enforcing child support orders. Title IV-D of the Social Security Act establishes child support services that are available for all families with a non-custodial parent, regardless of welfare status. The FY 2010 President's Budget request is $4.6 billion in net budget authority for CSE and Family Support Programs.

Child support collections play an important role in helping low-income working families. Custodial families that have never received TANF get all child support collected on their behalf. Child support collections on behalf of families receiving TANF and some arrearage collections on behalf of former TANF recipients are shared between the State and Federal Governments as reimbursement for providing TANF benefits. Beginning in FY 2009, the Federal Government now shares in the cost when States opt to distribute more collections directly to current and former TANF families. The Federal Government shares in the financing of this program by providing matching funds for general State administrative costs and paternity testing, as well as the funding of incentive payments. The CSE program also includes $10 million annually for grants to States to facilitate non-custodial parents' access to and visitation with their children.

The Recovery Act temporarily allows States to use Federal incentive payments as their State share of expenditures eligible for Federal match in FY 2009 and FY 2010. States receive Federal incentive payments based on their performance in paternity establishment, support order establishment, collection of current support and arrearages, and cost-effectiveness.

Other family support programs funded in this account include Payments to Territories and Repatriation. Payments to Territories funds approximately $35 million in State maintenance assistance programs for eligible aged, blind, and disabled residents of Guam, Puerto Rico, and the Virgin Islands, per Title XVI of the Social Security Act.

The Repatriation program, authorized by section 1113 of the Social Security Act and the Act of July 5, 1960, provides assistance to United States citizens and their

Presidential Initiative: Home Visitation

The President's FY 2010 Budget includes a legislative proposal for a new mandatory program which would provide funds to States to establish and expand evidence-based home visitation programs for low-income families. The Budget assumes $124 million in budget authority and $87 million in outlays, with the program growing to $1.8 billion in outlays in FY 2019.

Home visitation is an investment that can yield substantial improvements in child health and development, and parenting abilities to support children's optimal cognitive, language, social-emotional, and physical development and reductions in child abuse and neglect. Research including several randomized control trial studies showed one particular model of home visitation resulted in Medicaid savings from reductions in preterm births, emergency room use, and subsequent births. Expanding proven effective home visitation programs is estimated to save Medicaid $664 million over ten years, including $189 million in 2019.

The program will provide States with funding primarily to support home visitation models that have been rigorously evaluated and shown to have positive effects on critical outcomes for children and families. Additional funds will be available to States to support promising models requiring additional evaluation.

HHS will develop and implement this initiative by drawing on the expertise of internal and external social services, health, and research experts. The initiative is presented in the ACF section of the Congressional Justification. The Department is consulting with other relevant offices on the most effective structure to administer the program. A coordinated strategy involving the Centers for Disease Control, the Centers for Medicare and Medicaid Services, the Health Resources and Services Administration, and the Administration for Children and Families will enable HHS to respond to varying approaches that States may wish to use to implement this initiative.

dependents who are returning from foreign countries and are deemed to be destitute, mentally ill, or in need of emergency evacuation due to threatened armed conflict, civil strife, or natural disasters. The cap for this program is $1 million annually.

Child Support Enforcement and Family Support Programs Legislative Proposals: The FY 2010 President's Budget includes several child support proposals aimed at increasing collections. The proposals also recognize that healthy families need more than financial support alone and increase resources for Access and Visitation Programs to support and facilitate non-custodial parents' access to and visitation with their children.

In FY 2010, these proposals will cost the Federal Government $3 million, while increasing collections to families by almost $8 million. Over five years, the combined proposals for this account will generate a net Federal cost of $27 million while increasing collections to families by nearly $320 million.

CHILDREN'S RESEARCH AND TECHNICAL ASSISTANCE

The FY 2010 President's Budget includes $58 million for activities in three areas: child support enforcement training and technical assistance; operation of the Federal Parent Locator Service (FPLS) which assists States in locating absent parents; and research on welfare and child well-being. Of the total, $12 million will fund CSE training and technical assistance, and $25 million will support FPLS operations. The remaining $21 million will fund welfare research ($15 million) and continue the National Survey of Child and Adolescent Well-Being ($6 million), a longitudinal study on the well-being of children who come into contact with the child welfare system.

FOSTER CARE AND PERMANENCY

The FY 2010 Budget request for the Foster Care, Adoption Assistance, Guardianship Assistance, and Independent Living programs is $7.3 billion in budget authority. These programs, authorized by Title IV-E of the Social Security Act, support safe living environments for vulnerable children and prepare older foster youth for independence.

Of the total Budget request, $4.7 billion in budget authority will support the Foster Care program, including maintenance payments to children. This is a $21 million increase from the FY 2009 level. The proposed level of funding will support approximately 174,300 children each month, about 4,300 fewer children than in FY 2009 as more children, in part due to placement of more children in permanent settings. The FY 2010 Budget also includes $4.5 billion in budget authority for the Adoption Assistance program, which supports families that adopt special-needs children. This is an increase of $91 million over the FY 2009 level. These funds will be used to provide maintenance payments to adoptive families, administrative payments for the costs associated with placing a child in an adoptive home, and training for professionals and adoptive parents. The proposed level of funding will support approximately 426,400 children each month, an increase of 14,600 children over FY 2009.

The Budget also contains $140 million in budget authority for the Independent Living Program, the same as the FY 2009 level. This program funds services for youth who will likely remain in foster care until they turn 18 and for former foster children between the ages of 18 and 21.

A Federal match equal to the Medicaid match rate for medical assistance payments (FMAP) is provided for State maintenance payments for foster care, adoption assistance, and guardianship assistance under Title IV-E of the Social Security Act. The Recovery Act temporarily increased the FMAP rate for these title IV-E entitlement programs by 6.2 percentage points. It is

Performance Highlight

The CSE program continues to make strong gains in child support collections, as well as support order and paternity establishment. In FY 2007:

- Child support collections reached $25 billion, a four percent increase from the previous year.
- CSE established paternity for over 1.7 million children, which is the same as the previous year.
- CSE surpassed its target of a 95 percent paternity establishment rate for all non-marital births in the previous year by three percentage points for actual results of 98 percent.
- CSE surpassed its target for establishing child support orders, generating support orders for 78 percent of all child support cases.
- For every dollar invested in the program, CSE collected $4.73 in child support, exceeding their target of $4.56. CSE aims to increase its cost-effectiveness ratio to $4.77 by FY 2010.

estimated that States will receive an additional $806 million between October 1, 2008 and December 31, 2010 due to this provision.

The Fostering Connections to Success and Increasing Adoptions Act of 2008: The Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) was enacted on October 7, 2008. The Act amends parts B and E of title IV of the Social Security Act to help connect family members, improve outcomes for children in foster care, provide for Tribal access to Federal foster care and adoption assistance funding, and improve incentives for adoption. The new law:

- Eliminates birth parent income as an adoption assistance eligibility requirement, effectively expanding the pool of eligible youth by 30 percent over nine years;
- Gives States the option to continue Foster Care and Adoption Assistance maintenance payments for youth ages 18-21;
- Permanently appropriates Title IV-E funding for Tribes, including Tribal technical assistance funds;
- Establishes a $15 million Family Connection grants program to help children who are in foster care or at risk of entering foster care reconnect with family members;
- Gives States the option to provide guardianship assistance payments through title IV-E;
- Expands training for child welfare agencies, relative guardians, and court personnel; and,
- Increases the discretionary bonus payments provided to States that increase adoption of children in foster care.

Foster Care and Permanency Performance: The Foster Care, Adoption Assistance, and Independent Living programs demonstrated success in improving safety, permanency, and well-being of children in FY 2007, the latest year for which complete performance data are available. Working with the States, these programs met the goal of minimizing disruptions to the continuity of family and other relationships for children in foster care by decreasing the number of placement settings per year for a child in care. In FY 2007, over 84 percent of children who had been in care less than 12 months had no more than two placement settings, exceeding the target of 80 percent.

The programs also met goals to provide children in foster care with permanency and stability in their living situations by improving the timeliness of reunification, if possible, and promoting guardianship or adoption when reunification was not possible. In FY 2007, over 42.2 percent of children exited foster care (within two years of placement) either through guardianship or adoption, exceeding the target of 35 percent.

Promoting Safe And Stable Families (PSSF): Promoting Safe and Stable Families is a program designed to assist States in coordinating services related to child abuse prevention and family preservation. This program has two distinct funding streams, one discretionary and one mandatory. The total FY 2010 Budget request for PSSF is $443 million. The mandatory portion of this Budget request provides funding for this capped entitlement at $380 million, the same level as FY 2009.

The Child and Family Services Improvement Act of 2006 (P.L. 109-288) reauthorized and amended the PSSF program for FY 2007 through FY 2011. The law created two set-asides: $20 million in FY 2010 to support State spending on monthly caseworker visits and $20 million for competitive regional partnership grants to increase the well-being of, and improve the permanency outcomes for, children affected by methamphetamine or other substance abuse. The law also limited administrative costs to 10 percent of the total State expenditures for PSSF, and reauthorized the basic Court Improvement Program without change through FY 2011.

Promoting Safe and Stable Families Performance: In FY 2007 the percentage of children in foster care without a case plan goal was reduced to 4.8 percent, exceeding the goal of 6.4 percent. By increasing the proportion of cases with a case plan goal developed in a timely manner, ACF is helping to ensure that there is a focus on moving children from foster care to a permanent home.

SOCIAL SERVICES BLOCK GRANT (SSBG)

SSBG is a capped entitlement which provides flexible grants to States for the provision of social services ranging from child care to residential treatment. SSBG is funded at $1.7 billion for FY 2010, which is the same as the FY 2009 funding level. States have broad discretion over the use of these funds. SSBG funds are allocated to States according to population size.

Social Services Block Grant Supplemental Funds for FY 2008: The Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009

(P.L. 110-329), appropriated $600 million in SSBG Supplemental funds to be allocated to qualifying States affected by hurricanes, floods, and other natural disasters in addition to Hurricanes Katrina and Rita in 2008. The funds can be used toward the traditional activities allowed under SSBG as well as for health and mental health services, and for repair, renovation and construction of health facilities. Three-fourths of the SSBG Supplemental funds were distributed to States with major disasters declared by the President occurring after January 1, 2008 but before September 30, 2008. The remaining amount was distributed to States recovering from Hurricanes Katrina and Rita. A total of 20 States and the Commonwealth of Puerto Rico received a portion of the $600 million supplemental funds.

ACF ENTITLEMENT – OUTLAYS OVERVIEW

(outlays in millions)

	2008	2009	2010	2010 +/- 2009
Current Law Outlays:				
Temporary Assistance for Needy Families	17,532	18,623	18,047	-576
Recovery Act TANF Supplemental Grants (non-add) /1	--	--	*319*	*+319*
Contingency Fund /2	348	1,219	185	-1,034
Recovery Act Emergency Contingency Fund /3	--	441	1,215	+774
Child Care Entitlement to States	2,909	2,927	2,938	+11
Child Support Enforcement and Family Support (net)	4,276	4,472	4,588	+116
Recovery Act Child Support Enforcement (non-add)	--	*426*	*590*	*+164*
Foster Care and Permanency	6,750	7,079	7,198	+119
Recovery Act Foster Care and Permanency (non-add) /4	--	*354*	*359*	*+5*
Children's Research and Technical Asst. (net)	57	66	62	-4
Promoting Safe and Stable Families (mandatory only) /5	343	370	376	+6
Social Services Block Grant /6	1,843	1,909	2,009	+100
Abstinence Education	14	31	15	-16
Total, Current Law Outlays	**34,072**	**37,137**	**36,633**	**-504**
Proposed Law Outlays:				
Child Support Enforcement and Family Support (net)	--	--	3	+3
Teen Pregnancy Prevention /7	--	--	20	+20
Home Visitation /8	--	--	87	+87
LIHEAP /9	--	--	329	+329
Proposed Law Outlays	**--**	**--**	**439**	**+439**
Total, Proposed Law Outlays	**34,072**	**37,137**	**37,072**	**-65**
Total, Proposed Law Outlays Excluding Recovery Act	**34,072**	**35,916**	**34,589**	**-1,327**

1/ The American Recovery and Reinvestment Act of 2009 (Recovery Act) extended the TANF Supplemental Grants through FY 2010.

2/ In FY 2006, the Deficit Reduction Act of 2005 extended the availability of unobligated Contingency Fund balances through FY 2010. The FY 2009 beginning balance was $1.3 billion. ACF estimates that at the end of FY 2009 the fund will be exhausted.

3/ The Recovery Act established a pre-appropriated $5 billion TANF Emergency Contingency Fund to address rising costs related to basic assistance and other related services.

4/ The Recovery Act provision increasing the FMAP rate is effective FY 2009 through the first quarter of FY 2011. FY 2010 outlays do not reflect these additional three months in FY 2011.

5/ Beginning in FY 2009, the Fostering Connections to Success and Increasing Adoptions Act of 2008 provides $15 million per year for Family Connection Grants.

6/ The FY 2008 Supplemental Budget included $600 million for SSBG to help States affected by Presidentially declared major disasters in 2008.

7/ The FY 2010 Budget assumes that the mandatory abstinence education will not be reauthorized and a newly authorized teen pregnancy prevention initiative is proposed. See ACF Discretionary Programs Section for further explanation.

8/ The President's Budget includes a new mandatory program for Home Visitation that assumes an increase in budget authority and resulting outlays over ten years.

9/ The President's Budget includes a new mandatory funding trigger for LIHEAP. See ACF Discretionary Programs Section for further explanation.

Note: ACF Entitlement budget authority is displayed on the ACF Entitlement - Budget Authority Overview table at the beginning of this section.

ACF ENTITLEMENT LEGISLATIVE PROPOSALS

(outlays in millions)

	2010	2010 - 2014	2010 - 2019
Home Visitation			
Phase in Home Visitation /1	+87	+1,899	+8,563
Subtotal, Home Visitation	**+87**	**+1,899**	**+8,563**
Low-Income Home Energy Assistance Program			
Create a LIHEAP Trigger /2	+329	+2,080	+4,330
Subtotal, LIHEAP	**+329**	**+2,080**	**+4,330**
Child Support Enforcement and Family Support Programs /3			
Federal Seizure of Accounts in Multi-State Financial Institutions	+1	-6	-16
Garnishment of Longshore and Harbor Worker's Compensation Act Benefits	--	-4	-9
Increase Access and Visitation Funding	+2	+32	+82
Expand EITC for Non-Custodial Parents Who Pay Child Support /4	--	+5	+10
Subtotal, Child Support Enforcement and Family Support Programs	**+3**	**+27**	**+67**
Teen Pregnancy Prevention (Mandatory) /5	+20	+208	+459
Subtotal, Teen Pregnancy Prevention	+20	+208	+459
Total, ACF Proposals	**+439**	**+4,214**	**+13,419**

1/ The President's Budget includes a new mandatory program for Home Visitation that assumes an increase in budget authority and resulting outlays over ten years. .....
2/ See ACF Discretionary Programs Section for further explanation.
3/ The estimates reflect total Federal impact including collections that reimburse foster care and TANF.
4/ Reflects ACF administrative costs associated with Treasury Department implementation of the proposal.
5/ The FY 2010 Budget assumes that the $50 million in mandatory abstinence education will not be reauthorized and a newly authorized teen pregnancy prevention initiative is proposed. See ACF Discretionary Programs Section for further explanation.

(dollars in millions)

	2008	2009 ARRA*	2009 Omnibus	2010	2010 +/- 2009 Omnibus
State and Community-Based Services					
Home and Community-Based Supportive Services	351	--	361	361	--
Nutrition Programs:					
Congregate Nutrition Services	411	65	434	434	--
Home-Delivered Nutrition Services	194	32	214	214	--
Nutrition Services Incentive Program	153	--	161	161	--
Subtotal, Nutrition Program	758	97	810	810	--
Preventive Health Services	21	--	21	21	--
Family Caregiver Support Services	153	--	154	154	--
Subtotal, State and Community-Based Services	1,284	97	1,346	1,346	--
Services for Native Americans					
Native American Nutrition and Supportive Services	27	3	27	27	--
Native American Caregiver Support Services	6	--	6	6	--
Subtotal, Services for Native Americans	33	3	34	34	--
Protection of Vulnerable Older Americans					
Long-Term Care Ombudsman Program	16	--	16	16	--
Prevention of Elder Abuse and Neglect	5	--	5	5	--
Subtotal, Protection of Vulnerable Older Americans	21	--	21	21	--
Program Innovations	15	--	18	13	-5
Aging Network Support Activities	31	--	42	44	+3
Health and Long-Term Care Programs **	*16*	--	*28*	*31*	
Alzheimer's Disease Demonstration Grants	11	--	11	11	--
Program Administration	18	--	19	21	+3
Medicare Enrollment Assistance Program ***	--	--	18	--	-18
Health Care Fraud and Abuse Control ***	3	--	3	3	--
Total, Program Level	**1,416**	**100**	**1,512**	**1,495**	-18
Less Funds From Other Sources					
Medicare Enrollment Assistance Program	--	--	-18	--	--
Health Care Fraud and Abuse Control	-3	-3	-3	-3	--
Total, Budget Authority	**1,413**	**97**	**1,491**	**1,491**	**--**
FTE	106		107	120	+13

*American Recovery and Reinvestment Act of 2009 (Recovery Act)

** Previously referred to as Choices for Independence

*** Funding from Medicare Trust Funds

ADMINISTRATION ON AGING

The mission of the Administration on Aging is to develop a comprehensive, coordinated and cost-effective system of home and community-based services that helps elderly individuals to maintain their independence and dignity in their homes and communities.

The FY 2010 Budget requests $1.5 billion for the Administration on Aging (AoA), the same as FY 2009. The Budget includes investments in strategies that will empower older individuals and their families to take control over their long-term care needs and supports AoA's core programs.

Looking Forward: Continued Investment in Health and Long-Term Care

The Budget requests $31 million under Aging Network Support Activities to continue the national implementation and evaluation of three health and long-term care programs: Aging and Disability Resource Centers (ADRCs), Evidence-Based Disease Prevention Programs and Nursing Home Diversion—that focus on giving older individuals and their caregivers the ability to improve and maintain their health, understand their long-term care options so they can better direct their care, and conserve and extend their personal resources, all through the use of low-cost, community-based service alternatives and preventive services.

Providing Home and Community-Based Support Services

The Budget requests $361 million for Home and Community-Based Supportive Services. These funds support a broad array of services that enable older individuals to remain healthy, while maintaining their independence, at home and in the community. This support includes access services such as transportation, case management, and information and referrals; in-home services such as personal care, chore, and homemaker assistance; and community services such as adult day care and physical fitness programs. In 2007, Home and Community-Based Supportive Services provided 29 million rides for critical daily activities, 28 million hours of assistance to seniors unable to perform daily activities, and nearly 8 million hours of care for older adults.

Ensuring Adequate Nutrition

The FY 2010 Budget includes $810 million for the Nutrition programs, including Congregate and Home-Delivered Nutrition services and the Nutrition Services Incentive Program. Balanced nutrition is crucial to maintaining cognitive and physical functionality and reducing chronic disease and disability. AoA's Nutrition services help seniors to improve their nutritional intake and remain at home. In 2007, Home-Delivered Nutrition Services provided 141 million meals to over 916,000 individuals, and Congregate Nutrition Services provided almost 95 million meals to 1.6 million seniors in a variety of community settings.

Family Caregiver Support

The FY 2010 Budget request includes $154 million for the National Family Caregiver Support Program, which supports family and informal caregivers by providing information, assistance, counseling, training, respite, and other services that help them care for their loved ones at home. Data from AoA's national surveys of caregivers indicate that almost half of caregivers who have nursing home-eligible care recipients indicate that their loved one would not have been able to stay in their home without these support services.

Focusing on Prevention

The Budget also requests $21 million for Preventive Health Services to support activities that educate older adults about the importance of healthy lifestyles and behaviors that can help to prevent or delay the need for costly medical interventions that result from chronic diseases and disabilities.

Native American Nutrition, Support and Caregiver Activities

The FY 2010 Budget provides $34 million for Native American seniors, including $27 million for nutrition and supportive services and $6 million for Native

Recovery Act

The American Recovery and Reinvestment Act provided $100 million for meals to assist communities and local aging services agencies affected by increased demand for services and rising food costs due to the economic downturn and the growing number of older adults. The Recovery Act provided:

- $65 million for Congregate Nutrition;
- $32 million for Home-Delivered Nutrition Services; and
- $3 million for Native American Nutrition Services.

These funds will provide an estimated 13.8 million meals to approximately 181,300 seniors.

American caregivers and the seniors they assist. These programs help to reduce the need for costly institutional care and medical interventions. In 2007, this funding provided 4.3 million Congregate and Home-Delivered meals and approximately 933,000 rides were provided to Native Americans for rides to meal sites, medical appointments and other critical activity locations.

PROTECTING ELDER RIGHTS

The FY 2010 Budget includes $21 million to improve the quality of care for residents of long-term care facilities through the Long Term Care Ombudsman Program and to increase public and professional awareness of elder abuse through the Prevention of Elder Abuse, Neglect and Exploitation Program. Together these activities help protect the rights and dignity of vulnerable elders.

SUPPORTING THE NATIONAL AGING SERVICES NETWORK

In addition to the $31 million for ADRCs, Evidence-Based Prevention and Nursing Home Diversion, the budget includes $13 million for other Aging Network Support Activities that help seniors and their families obtain information about their care options and benefits. These funds support activities such as the National Eldercare Locator, Pension Information and Counseling program, national resource centers, and Senior Medicare Patrol projects that train seniors to detect fraud and abuse in their Medicare and Medicaid statements.

The FY 2010 Budget requests $13 million for Program Innovations to maintain funding for ongoing activities of national significance, including national resource centers, senior legal help lines, and the National Alzheimer's Call Center, and to continue support for innovative demonstration initiatives such as the Community Innovations for Aging in Place Program and Civic Engagement. Traditionally, these funds have been a source of support for AoA to identify, demonstrate and disseminate the results of best practices throughout the national aging services network.

MEETING THE NEEDS OF THOSE WITH ALZHEIMER'S DISEASE

The Budget includes $11 million for the Alzheimer's Disease Demonstration Grants Program that helps ensure AoA's core programs expand the availability of diagnostic and support services for persons with Alzheimer's disease, their families and their caregivers through competitive grants.

PROGRAM ADMINISTRATION

A total of $21 million is requested in the FY 2010 Budget for program management and support activities, and to better address the needs of the growing aging population.

Health and Long-Term Care in Home and Community Based Settings

As part of the President's agenda to improve long-term care, funding will support:

- **Evidence-Based Prevention**—especially Chronic Disease Self Management Programs—use low-cost, community-level interventions to assist seniors to make behavioral changes that have proven effective in reducing the risk of disease, injury and disability;
- **Aging and Disability Resource Centers (ADRCs)—** offer single-entry points to help individuals make informed decisions about their care options, plan ahead for their long-term care needs, and streamline access to long-term care services supported with public and/or private funds; and
- **Nursing Home Diversion**—provides non-Medicaid home and community-based services to help high-risk individuals avoid nursing home placement and spend-down to Medicaid.

Performance Highlight

Increasing the number of consumers with severe disabilities (defined as persons with three or more Activities of Daily Living limitations) who receive selected home and community-based services is one of AoA's long-term goals. In 2007, AoA exceeded the target for increasing the number of consumers with severe disabilities by 10 percent, and served over 359,143 clients.

(dollars in millions)

	2008	2009 Omnibus	2010	2010 +/- 2009 Omnibus
Commissioned Corps Transformation/Training	4	15	15	--
Health Diplomacy Initiative	--	7	2	-5
Other General Departmental Management 1\	351	374	393	+19
Evaluation Activities	47	47	60	+13
Health Care Fraud and Abuse Control	5	6	6	--
Subtotal, GDM Program Level	407	449	476	27
Less funds from other sources:				
Evaluation Activities	47	47	60	+13
Health Care Fraud and Abuse Control	5	6	6	--
Total, GDM Budget Authority	355	396	410	+14
FTE	1,341	1,556	1,630	+74

1\ GDM Budget Authority includes $1M that will be transferred to NIH for autism. This transfer also occurred in 2008 & 2009

General Departmental Management supports the Secretary in her role as chief policy officer and general manager of the Department.

The FY 2010 Budget request for General Departmental Management (GDM) is $476 million, a net increase of $27 million over the FY 2009 Omnibus.

The GDM account supports those activities associated with the Secretary's roles in administering and overseeing the organization, programs, and activities of the Department. These activities are carried out through 15 Staff Divisions.

The FY 2010 Budget request provides increased funding for a variety of critical activities.

Commissioned Corps: The FY 2010 Budget request includes $15 million for the Transformation of the Public Health Service's (PHS) Commissioned Corps, the same as FY 2009. This Budget supports the Department's multi-year process to revitalize and improve the Corps' ability to respond to public health emergencies and deliver timely and effective public health services in underserved and hazardous situations.

Transformation activities will focus on modernizing the force strength and management of the Commissioned Corps, streamlining the assignment and deployment process, and increasing the ability to recruit talented candidates into the Commissioned Corps. To accomplish these goals, FY 2010 funding will be used to develop new systems to support total force management; train and equip officers to respond to emerging public health threats and situations; and to improve response operations.

Health Diplomacy Initiative: The FY 2010 Budget includes $2 million, for an initiative managed by the Office of Global Health Affairs (OGHA). The funding will support continued HHS presence and engagement to collaborate with Central American Governments to provide medical education and training. This funding would continue most effective training efforts.

Other General Departmental Management: The FY 2010 Budget request includes $393 million to fund activities within offices which provide leadership, policy, legal, and administrative guidance to HHS

components, and also includes funding to continue ongoing activities.

Office of Population Affairs OPA/Adolescent Family Life (AFL): The FY 2010 Budget includes $30 million to provide support for the AFL demonstration and research program authorized under Title XX of the PHS Act. Through the grants awarded under this program, AFL provides funding in three areas: care demonstration projects, prevention projects, and research projects. The majority of funds for this effort will support programs whose effectiveness has been demonstrated through rigorous evaluation. A smaller portion of funds will be available for promising teen pregnancy prevention programs that require further evaluation to determine effectiveness.

Office of Minority Health (OMH): The OMH Budget request of $56 million, an increase of $3 million above the FY 2009. The Budget request will provide funding to continue disease prevention, health promotion, service demonstration, and educational efforts to reduce and ultimately eliminate disparities in racial and ethnic minority populations. The $3 million will assist States in strengthening their existing health care infrastructure for serving racial and ethnic minorities, including developing State-wide collaborations and ensuring the use of best practices. The increase is part of an HHS-wide effort to more effectively address diversity in FY 2010.

Office on Women's Health (OWH): As in FY 2009, the OWH Budget request of $34 million will provide funding to continue the advancement of women's health programs through the promotion and coordination of research, service delivery, and education throughout HHS agencies and offices, with other government organizations, and with consumer and health professional groups.

Minority HIV/AIDS: As in FY 2009, the FY 2010 Budget includes $52 million to support innovative approaches to HIV/AIDS prevention and treatment in minority communities disproportionately impacted by this disease. These funds allow the Department to continue priority investments and public health strategies targeted to reduce the disparities and burden of HIV/AIDS in racial and ethnic minority populations.

Afghanistan Health Initiative (AHI): Included in the FY 2010 Budget request for OGHA is $6 million to continue support of HHS health care initiatives in Afghanistan, particularly in the areas of improving the quality of maternal and neo-natal health care for Afghan mothers and their babies. The AHI works to increase the core knowledge and clinical skills of the physicians and other health-care professionals at Rabia Balkhi Women's Hospital, as well as helping the Ministry of Public Health implement its national health strategy and build capacity to sustain these public-health and medical investments in Rabia Balkhi Women's Hospital.

PHS Evaluation Funds: The FY 2010 Budget request also includes $60 million, an increase of $13 million over FY 2009 for PHS Evaluation Funds, as authorized by section 241 of the Public Health Service Act. In addition to the new investments in Health Reform, these funds will support policy research and evaluation activities in the Office of the Assistant Secretary for Planning and Evaluation, as well as evaluation activities in the Office of Public Health and Science and the Office of the Assistant Secretary for Resources and Technology.

Parklawn Lease Procurement: The FY 2010 Budget also includes $102 million to support the HHS wide total costs for a new lease procurement process affecting over 2,800 staff in the Parklawn Building and three other smaller offices in suburban Maryland. The current lease for the Parklawn Building expires in July, 2010. Funding for this activity has been requested within the Public Health and Social Services Emergency Fund.

(dollars in millions)

	2008	2009 Omnibus	2010	2010 +/- 2009 Omnibus
Total, Program Level.....	64	65	71	+6
FTE.....	366	366	378	+12

The Office of Medicare Hearings and Appeals provides an independent forum for the fair and efficient adjudication of Medicare appeals for beneficiaries and other parties. This mission is carried out by a cadre of knowledgeable Administrative Law Judges exercising judicial and decisional independence under the Administrative Procedures Act, with the support of a professional legal and administrative staff.

The FY 2010 Budget requests $71 million for the Office of Medicare Hearings and Appeals (OMHA), a net increase of $6 million over FY 2009. Funds are being requested from the Federal Hospital Insurance and Supplementary Medical Insurance Trust Funds to hear cases under Title XVIII of the Social Security Act, and related provisions in Title XI of the Act.

OMHA was established by Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). MMA transferred the responsibility for hearing Medicare appeals at the Administrative Law Judge (ALJ) level – the third level of Medicare claims appeals – from the Social Security Administration to the HHS Office of the Secretary. In addition, the Medicare Benefits Improvement and Protection Act of 2000 (BIPA) mandated that such ALJ appeals be heard within 90 days after receipt of a request from a Medicare appellant for a hearing. OMHA began processing cases on July 1, 2005; to date it has received almost 550,000 claims from across the United States for Medicare Parts A, B, C, and D appeals, as well as Medicare entitlement and eligibility appeals. During FY 2008, OMHA received a total of 183,326 claims, an increase of 33 percent over its FY 2007 caseload.

OMHA administers appeals in four field offices, including the Southern Field Office in Miami, Florida; the Midwestern Field Office in Cleveland, Ohio; the Western Field Office in Irvine, California; and the Atlantic Field office in Arlington, Virginia. OMHA extensively utilizes hearings held via video-teleconference (VTC) and telephone, in order to provide appellants with hearings which are timely, close to their homes, and with a broad array of access points. VTC technology, which is commonly used throughout the country in courtrooms and for telemedicine, plays a critical role in OMHA's ability to both meet the BIPA timeframes and provide expanded access for appellants to ALJ hearings.

In FY 2010, OMHA projects that it will receive 36 percent more claims than in FY 2009, including claims resulting from the permanent expansion to all 50 States of the Recovery Audit Contractor (RAC) program administered by the Centers for Medicare & Medicaid Services. The demonstration phase of the RAC program in FY 2008 and FY 2009 included just five States.

With the requested funding level of $71 million, OMHA will be able to process the projected ALJ appeals workload within the BIPA mandated timeframes. OMHA will accomplish this by continuing to utilize state-of-the-art technology, maintain necessary staffing levels, and offer high levels of access for appellants to hearing sites and services.

OFFICE OF THE SECRETARY
OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

(dollars in millions)

	2008	2009 ARRA*	2009 Omnibus	2010	2010 +/- 2009 Omnibus
Budget Authority	42	2,000	44	42	-1
PHS Evaluation Funds	19	--	18	19	+1
Total, Program Level	**61**	**2,000****	**61**	**61**	--
FTE	30	--	30	65	+35

*American Recovery and Reinvestment Act of 2009 (Recovery Act)
**The Recovery Act appropriation to ONC includes $20 million to be transferred to NIST.

The Office of the National Coordinator for Health Information Technology leads, coordinates, and stimulates public and private sector activities that promote the development, adoption, and use of health information technologies to achieve a healthier Nation.

The FY 2010 Budget request for the Office of the National Coordinator for Health Information Technology (ONC) is $61 million, $0.1 million above FY 2009, excluding Recovery Act funds. The FY 2010 President's Budget includes resources for ONC to continue its current activities as the Federal health IT leader and coordinator. This role will be vital to achieving the President's health IT initiative and accelerating the adoption of health IT and utilization of electronic health records. The FY 2010 Budget request, in conjunction with the $2 billion appropriated to ONC under the Recovery Act, will enable HHS to implement the Health Information Technology for Economic and Clinical Health (HITECH) Act.

The Recovery Act included both additional resources and a new authorization to guide the Federal government's health IT activities. The Recovery Act provided $2 billion for ONC to implement the HITECH Act, which authorizes the Office of the National Coordinator; two new Federal Advisory Committees to guide standards and policy development processes; new grant and loan programs; and increased privacy and security protections.

In addition to funds requested within ONC, the FY 2010 Budget request for other HHS divisions includes funds to advance the Administration's health IT agenda. The Budget request includes $45 million in AHRQ to advance the use of health IT to enhance patient safety, and $2 million in ASPE for independent evaluations of electronic health record adoption and economic factors influencing health IT in coordination with ONC. In addition, the Budget request for CMS includes resources to conduct the second year of a demonstration project to encourage small physician practices to adopt electronic health records.

STANDARDS DEVELOPMENT AND IMPLEMENTATION

Standards are a critical element of the foundation of the national health IT agenda and a necessary building block for achieving the President's health IT goals. ONC's FY 2010 Budget request includes funds to support the development of health data standards and to ensure they are available for both private sector and Federal use. This funding will support the ongoing standards harmonization process, which is required for IT systems to exchange data across different health care settings. In

Recovery Act

The Recovery Act makes a down payment on health care reform by accelerating the adoption of health information technology and utilization of electronic health records. Building on this unprecedented investment, the Administration will continue efforts to further the adoption and implementation of health information technology—an essential tool in modernizing the health care system.

FY 2010, ONC will continue to support technology certification activities to ensure that the certification criteria for health IT products incorporates the most recent standards. These activities provide a consolidated resource for Federal agencies as they transition to harmonized standards and advance the national health IT agenda.

In FY 2010, ONC will also continue implementing the new processes outlined in the HITECH Act authorization for standards development. These activities include a Health IT Policy Committee and a Health IT Standards Committee. The Health IT Policy Committee will provide policy recommendations related to the implementation of a nationwide health information technology infrastructure. The Health IT Standards Committee will recommend standards, implementation specifications, and certification criteria for the electronic exchange and use of health information. ONC will also involve stakeholders and fulfill the unprecedented transparency and accountability reporting requirements for recipients of Recovery Act funding.

PRIVACY AND SECURITY

The FY 2010 Budget supports the continued development of appropriate Federal privacy and security protections of electronic health information, and to support State consensus efforts to address patient protections. Ensuring adequate Federal protections and facilitating multi-State collaboration is essential to building public confidence and trust in national health information exchange.

In FY 2010, ONC will continue working with partners, such as the HHS Office of Civil Rights, CMS, States, and other stakeholders to protect patients' health information. ONC will also continue to support the implementation and development of HITECH Act privacy and security regulations and guidance.

Presidential Initiative

The President's health IT initiative aims to accelerate the adoption of health IT and utilization of electronic health records. Computerizing America's health records in five years, while protecting the privacy and security of personal health information, is expected to improve the quality of health care, prevent unnecessary health care spending, and reduce medical errors.

DEVELOPING A TECHNICAL ARCHITECTURE TO ADVANCE ADOPTION OF HEALTH IT

Transitioning the medical and health industry to capitalize on the advantages of reliable and secure health information exchange requires multiple changes to our healthcare system. The FY 2010 Budget request includes support for expanding health information exchange network capabilities across additional markets and communities. A network for health information exchanges is a prerequisite to actually exchanging health information electronically. In FY 2010, ONC will continue supporting Recovery Act activities to develop a national health information network.

MEASURING SUCCESS

In FY 2010, ONC will continue to define measures of success and report on these measures as appropriate. ONC will use pre-existing performance measures as well as the milestones and objectives of the Federal Health IT Strategic Plan in developing these measures. ONC will update the Federal Health IT Strategic Plan in FY 2009. ONC will also measure its success by funding surveys on surveys of the adoption rates of electronic health records among physicians and hospital

Performance Highlight

The Federal Health Architecture (FHA) has made software available to the public to enable health information technology systems to communicate with the Nationwide Health Information Network (NHIN). The FHA – an E-Gov initiative led by ONC – has made the free software, called CONNECT, and supporting documentation available at www.connectopensource.org.

The CONNECT software is the outcome of a 2008 decision by more than 20 Federal agencies to begin work on connecting their health IT systems to the NHIN. Rather than individually building the software required to make this possible, the Federal agencies, through the FHA, created CONNECT. This shared software solution can be reused by each agency within its own environment. The Department of Defense, Veterans Affairs, the Social Security Administration, the Centers for Disease Control and Prevention, the Indian Health Service, and the National Cancer Institute have tested and demonstrated CONNECT's ability to share data among each other and with private sector organizations.

OFFICE OF THE SECRETARY
OFFICE FOR CIVIL RIGHTS

(dollars in millions)

	2008	2009 Omnibus	2010	2010 +/- 2009 Omnibus
Total, Program Level.....	34	40	41	+1
FTE.....	228	255	270	+15

The Office for Civil Rights promotes and ensures that people have equal access to and opportunity to participate in and receive services in all HHS programs without facing unlawful discrimination and that the privacy of their health information is protected while ensuring access to care. Through prevention and elimination of unlawful discrimination and by protecting the privacy of individually identifiable health information, OCR helps HHS carry out its overall mission of improving the health and well-being of all people affected by its many programs.

The FY 2010 Budget request is $41 million for the Office for Civil Rights (OCR), an increase of $1 million over FY 2009. The budget supports OCR's activities as the primary defender of the public's right to nondiscriminatory access to and receipt of Federally funded health and human services – from hospitals and nursing homes to Head Start and senior centers. In addition, the budget supports OCR's significantly expanded compliance responsibilities that protect the rights of individuals' personal health information under the Privacy Rule issued pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

OCR assesses compliance with nondiscrimination and Privacy Rule requirements through:

- complaint investigation, resolution, and monitoring;
- public education;
- technical assistance; and
- compliance reviews, including civil rights reviews of new Medicare provider applicants.

OCR's work protects individual rights while supporting HHS goals for strengthening the health and well being of individuals, families, and communities by improving access to HHS programs.

Key priorities for OCR in FY 2009 and FY 2010 include: ensuring understanding of and compliance with the HIPAA Privacy Rule; implementing additional privacy protections for genetic information; promoting adequate privacy protections in health information technology; enforcing the confidentiality protections afforded to patient safety information; increasing non-discriminatory access to quality health care and human services, including adoption, foster care, and TANF; promoting best practices for effective communication in hospital settings with persons who are deaf or hard of hearing and persons of limited English proficiency; strategically disseminating an OCR- developed Federal civil rights curriculum for medical schools to help narrow disparities in health care quality, access and patient safety; supporting appropriate services in the most integrated setting for persons with disabilities; and promoting non-discrimination and privacy protections in emergency preparedness and response activities.

Through these varied efforts, OCR promotes integrity in the expenditure of Federal funds by ensuring that these funds support programs which provide access to services free from discrimination on the basis of race, color, national origin, disability, age, religion and sex. OCR's efforts also promote public trust and confidence that the health care system will maintain the privacy of protected health information while ensuring access to care.

ENSURING PRIVACY AND CONFIDENTIALITY IN HEALTH CARE

HIPAA – Health Information Privacy: OCR is responsible for administering and enforcing the HIPAA Privacy Rule, which protects the privacy of individually identifiable health information

maintained or transmitted by health plans, health providers, and clearinghouses. Since the compliance date of April 14, 2003, OCR has responded to more than 33,000 complaints. Of the approximately 11,000 complaints where OCR has had the authority to investigate, OCR found no violation in about 3,600 and has obtained corrective action from the investigated entities in over 7,200 cases.

Privacy Provisions of the Genetic Information Non-discrimination Act of 2008 (GINA): GINA protects individuals against discrimination by employers and health plans based on an individual's genetic information. To help implement these important new Federal protections, OCR will amend the HIPAA Privacy Rule, as required by GINA, to prohibit health plans from using or disclosing an individual's genetic information for underwriting purposes.

Privacy and Security Provisions of the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009: In FY 2009 and FY 2010 OCR will develop the regulations and guidance required under Subtitle D of the HITECH Act for the purpose of strengthening and enhancing privacy protections of the HIPAA Privacy Rule. Additionally in accordance with the Act, OCR will expand its significant outreach efforts by implementing a comprehensive national education initiative, to be conducted in a variety of languages, which will enhance public transparency regarding the uses of protected health information and the rights of individuals with respect to those uses.

OCR will continue to provide policy support to HHS leadership to ensure consideration of privacy and civil rights issues in the development of standards for a national health information infrastructure.

Patient Safety: OCR is taking a lead role in fulfilling the Department's mandate to improve patient safety and reduce the incidence of events that adversely affect patient safety by establishing and enforcing the confidentiality protections afforded by the Patient Safety and Quality Improvement Act of 2005.

Ensuring Non-Discriminatory Access to Health Care and Human Services

OCR works to ensure non-discriminatory access to HHS-funded health and human services regardless of race, color, national origin, disability, age, religion or sex, and to reduce health disparities.

OCR investigates and resolves complaints, initiates compliance reviews, and provides technical assistance to programs receiving Federal financial assistance. OCR works with Federal and State partners, providers and community- and faith-based organizations to ensure non-discriminatory access to health and human services. For example, OCR is partnering with the American Hospital Association and 17 state and regional hospital associations to facilitate effective communication in hospitals with persons who are deaf or hard of hearing and persons with limited English proficiency.

In FY 2010, OCR will continue to focus on equal access to quality health services to eliminate health disparities and a broad range of non-discrimination issues in human services, including adoption, foster care, emergency preparedness activities, and TANF. Also, as part of its effort to ensure that all recipients of Federal financial assistance are aware of their obligations under Federal civil rights laws, OCR will promote accessibility of health information technology for underserved populations, including people with limited English proficiency and those with disabilities.

Olmstead: OCR is the HHS agency with authority and responsibility to protect the rights of persons with disabilities under the Americans with Disabilities Act. It plays a leading role in working with the States to achieve community integration for individuals with disabilities in accordance with the Supreme Court's *Olmstead v. L.C.* decision. For example, in FY 2008 OCR entered into a statewide *Olmstead* settlement agreement in which the State of Georgia has committed to developing adequate community services for all persons with disabilities in public and private institutions and at risk of institutionalization, with an individual focus the more than 2,500 individuals currently institutionalized in eight Georgia psychiatric and developmental disabilities facilities.

OFFICE OF THE SECRETARY
SERVICE AND SUPPLY FUND

(dollars in millions)

	2008	2009	2010	2010 +/- 2009 Omnibus
Non-PSC	54	44	38	-6
PSC	706	795	800	+5
Revenues	760	839	838	-1
Non-PSC	114	127	127	--
PSC	1,104	1,249	1,249	--
FTE	1,218	1,376	1,376	--

The Service and Supply Fund provides consolidated financing and accounting for business-type operations which involve the provision of common services to customers at HHS and other government departments and agencies.

The Service and Supply Fund (SSF) provides consolidated financing and accounting for business-type operations which involve the provision of common services to customers. The SSF is governed by a Board of Directors, consisting of representatives from each of the Department's ten Operating Divisions (OPDIVs) and the Office of the Secretary Staff Divisions (STAFFDIVs). A representative from the Office of Inspector General (OIG) serves as a non-voting member. The SSF does not have its own appropriation, and is funded entirely through charges to its customers (HHS OPDIVs and STAFFDIVs, plus other Federal agencies) for their usage of goods and services. Each activity financed through the SSF is billed to the Fund's customers, based on either fee-for-service billing determined by actual usage of service or an allocated methodology.

Many of the Fund's Activities and business lines are based at the Program Support Center (PSC), and they represent the largest portion of the SSF budget. The Non-PSC activities, many of which facilitate compliance with public laws, regulations, or other Federal management guidelines, make up the remainder of SSF Activities.

In FY 2009, the PSC realigned functions of several services and retitled the Enterprise Support Service (ESS) the Information and Systems Management Service (ISMS). PSC products and services are provided in broad business areas described below.

ADMINISTRATIVE OPERATIONS SERVICES (AOS)

AOS provides a wide range of administrative and information technical services within the Department, both at headquarters and in the regions, and to customers throughout the Federal government. Services include: HHS payroll processing, building management and operations, safety, security services, lease management, alterations and maintenance, parking management, locator services and supply and inventory management. AOS also provides shipping and labor services, real property surpluses, mail and messenger services, conference room facilities support services, graphic design, printing, and copier maintenance throughout HHS.

FEDERAL OCCUPATIONAL HEALTH SERVICE

The Federal Occupational Health Service (FOHS) provides occupational health services for Federal employees, including health and wellness programs, employee assistance, work/life, and environmental health and safety services. Over 1.5 million Federal employees in 45 Federal departments and agencies are serviced by FOHS.

FINANCIAL MANAGEMENT SERVICE (FMS)

FMS supports HHS financial operations through the provision of fund accounting, disbursement, financial reporting, financial statement preparation, payroll accounting, and debt management and collection services. It supports Federal grantor and contracting agencies efforts to negotiate and approve indirect costs, fringe benefits and other specialty rates used by not-for-profit organizations receiving Federal awards. Lastly, grant disbursement, cash management, and grant accounting support services are also provided.

INFORMATION AND SYSTEMS MANAGEMENT SERVICE (ISMS)

ISMS provides high-quality information technology and technical services including: human resource systems; Freedom of Information Act (FOIA) on implementation and records management; Web content and publications management; IT infrastructure operations and consulting services; overseeing the PSC information systems security program; maintenance of the Unified Financial Management System (UFMS) and the HHS Consolidated Acquisition System.

Strategic Acquisition Service (SAS): The SAS is responsible for providing leadership, guidance, and supervision to the procurement operations of the PSC and for improving procurement operations within HHS. The SAS provides acquisition services, strategic sourcing services (including a Strategic Sourcing Center of Excellence); and provides pharmaceutical, medical, and dental supplies to HHS and other Federal agencies.

Human Resources (HR) Activities: The HR Centers represent a consolidation of human resources services within the Department, with sites located in Rockville and Baltimore, Maryland, and Atlanta, Georgia. The centers provide human resources strategic programs, customer service, and workforce relations support for HHS customers.

Below are descriptions of Non-PSC activities, many of which facilitate compliance with public laws, regulations, or other federal management guidelines.

Acquisition Integration and Modernization (AIM): AIM creates a seamless integration of HHS-wide acquisition process standardization, internal controls and oversight, and performance measurement inputs to serve employees, customers and vendors. AIM is used to improve a number of acquisitions-related processes related to purchase cards, acquisition plans, interagency contracting, and emergency contracting procedures.

Audit Resolution: Audit Resolution, as mandated by P.L. 96-304 and P.L. 98-502, resolves grantee audit findings within a statutorily mandated six month period.

Claims: Claims does mission critical work that is required by the Federal Tort Claims Act (FTCA). This act requires claimants to file administrative claims with the responsible agency before filing suit against the United States in Federal court.

Commissioned Corps Force Management (CCFM): CCFM provides personnel support to active-duty, inactive reserve and retired PHS Commissioned Officers as well as force management activities for the Corps as a whole.

Office of Small and Disadvantaged Business Utilization: The Small Business Office provides leadership, guidance and recommendations to insure that small businesses are given an equitable opportunity to participate in the provision of goods and services to HHS.

TAGGS, DCIS, and HPO & CSM: Several activities focus on the provision of competitive sourcing, procurement, and grants databases. The Tracking Accountability in Government Grants System (TAGGS) is HHS' central repository of grant award data. The publicly searchable database houses HHS discretionary and mandatory grant funding data awarded from 1995 to the present. The Departmental Contracts Information System (DCIS) serves as the central repository for Department-wide procurement data, and is the primary system used by HHS to fulfill procurement reporting requirements under the Federal Procurement Data System Next Generation/OMB, which is mandated by Public Law 93-400. This system compiles contract information to produce geographically-based reports to OMB and Congress. High Performing Organizations and Commercial Services Management (HPO & CSM) maintains a database to gather Federal Activities Inventory Reform Act inventory data at all levels of the Department.

Web Communications and New Media Division (WCD): The WCD is responsible for HHS Department Web sites. The new Web Policy Tester will enhance Section 508 Compliance efforts and improve web page maintenance efforts.

Homeland Security Presidential Directive 12 (HSPD-12): The HSPD-12 is new to the Fund. This activity is managed by the Office of Security and Strategic Information and addresses control of "physical access" to buildings.

OFFICE OF THE SECRETARY
RETIREMENT PAY & MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

(dollars in millions)

	2008	2009 Omnibus	2010	2010 +/- 2009 Omnibus
Retirement Payments	304	339	356	+17
Survivor's Benefits	21	20	25	+5
Medical Care - Active Duty, Retirees and Survivors	76	76	94	+18
Accrued Medical Benefits for over-65	37	35	36	+1
Total, Budget Authority	**438**	**470**	**511**	**+41**

The FY 2010 Budget of $511 million is a net increase of $41 million over FY 2009. This Budget request provides for annuities retirement payments of retired Public Health Service (PHS) Commissioned Corps Officers and payments to survivors of deceased retired officers; and medical care to active duty PHS commissioned officers, retirees, and dependents of members and accrued medical benefit payments for PHS Commissioned Corps officers and beneficiaries over age 65.

The Budget also funds the provision of medical care to active duty and retired members of the Corps under the age of 65, and dependents of deceased members. This account includes payments to the Department of Defense Medicare-eligible Retiree Healthcare Funds for the accrued costs of health care for beneficiaries over the age of 65.

The Budget reflects increased costs in medical benefits, an annualization of amounts paid to retirees and survivors, and a net increase in the number of retirees and survivors during FY 2010.

OFFICE OF INSPECTOR GENERAL

(dollars in millions)

	2008	2009 ARRA*	2009 Omnibus	2010	2010 +/-2009 Omnibus
Direct discretionary appropriation	43	17	45	50	+5
Discretionary HCFAC			19	30	+11
Mandatory HCFAC	170		177	177	--
Medicaid Integrity Program	25		25	25	--
Medicaid Oversight		31	25		-25
Audit and Investigations Reim	10		10	10	--
Total, Program Level	**248**	**48**	**301**	**292**	**-9**
FTE	1,518	60	1,538	1,591	

*American Recovery and Reinvestment Act of 2009 (Recovery Act)

Under the authority of the Inspector General Act, the Office of Inspector General improves HHS programs and operations and protects them against fraud, waste, and abuse. By conducting independent and objective audits, evaluations, and investigations, the OIG provides timely, useful, and reliable information and advice to Department officials, the Administration, the Congress, and the public.

The FY 2010 Budget request for the Office of Inspector General (OIG) is $50 million, a net increase of $5 million over FY 2009. In addition to the discretionary appropriation, OIG will continue to receive mandatory funding through various appropriations in FY 2010, which include the Health Care Fraud and Abuse Control Program, authorized by the Health Insurance Portability Act of 1997 and the Medicaid Integrity Program, authorized by the Deficit Reduction Act of 2005.

OIG will use its discretionary funding in FY 2010 to continue providing program integrity and oversight efforts that promote economy, efficiency, and effectiveness in the management and operation of more than 300 programs in HHS. These programs are implemented by every agency of HHS and include significant Administration priorities such as health information technology and food security.

In addition to OIG's oversight of HHS programs using the discretionary appropriation, during FY 2010 OIG will continue to use its mandatory appropriations for efforts that protect the safety of Medicare and Medicaid program beneficiaries and contribute to the financial solvency of the programs.

Recovery Act

OIG received $48 million through the Recovery Act. $17 million will be used for Department-wide Recovery Act oversight; and $31 million will be used for Medicaid oversight.

DISCRETIONARY PRIORITIES

Oversight of Food, Drug and Medical Device Safety: OIG has elevated the priority of its oversight responsibilities of public health agencies – such as FDA and NIH – in response to several high-profile issues related to food, drug and medical device safety. These agencies are required to have policies and programs in place that create safeguards to ensure the integrity of medical research endeavors, protect human research subjects, and provide for pre-approval and post-approval monitoring of regulated medical products and treatments. OIG will continue its oversight and inspection work in this critical area during FY 2010.

Grants Oversight: HHS receives and distributes more grant money than all other Federal agencies combined. Accordingly, OIG will continue providing oversight to ensure that HHS grants are appropriately monitored and managed throughout the grant life-cycle. In FY 2010 OIG will continue to assess the mechanisms in place to ensure that proper procedures are used to award and fund grants, account for expenditures, and verify that they are only used for authorized purposes.

An additional $1.2 million is provided in FY 2010 for three state

component error rate reviews for Temporary Assistance for Needy Families as part of its Improper Payments Information Act monitoring activities.

Child Support Enforcement Program: OIG will continue to provide coverage of all 50 States and the District of Columbia through its multi-agency task forces that identify, investigate, and prosecute individuals who willfully avoid payment of their child support obligations under the Child Support Recovery Act. OIG's task forces bring together State and local law enforcement and prosecutors, United States Attorneys' Offices, United States Marshals Service, and State and county child support personnel, as well as other interested parties.

Health Information Technology: HHS has a significant role in advancing the development and implementation of a national health information network. OIG will continue its oversight efforts of HHS' health information technology programs and objectives by monitoring HHS' implementation efforts and examining HHS grantees' compliance with applicable requirements.

Ethics Program Oversight and Enforcement: OIG has long been involved in oversight and enforcement related to the Department's ethics program. Prior OIG work has identified vulnerabilities in the Department's oversight of outside activities and potential conflicts of interest. OIG is directing continued attention to ensuring the effectiveness of the Department's ethics program and management of conflicts of interest.

Other Discretionary Priorities: OIG's funding in FY 2010 will also support continued oversight and compliance efforts, including the annual financial statement audits and Federal Information Security Management Act compliance. This funding will also enable OIG to continue funding the security detail for the HHS Secretary.

MANDATORY PRIORITIES

Health Care Fraud and Abuse Control Program and Medicaid Integrity Program: Several mandatory appropriations fund OIG's oversight of the Medicare and Medicaid programs. OIG works closely with CMS, other HHS agencies, DOJ and State governments to recover funds owed to the Medicare Trust Fund or CMS.

In FY 2010 OIG will continue this important work by building upon existing research and developing independent and objective assessments of threats to program integrity. OIG will also use available funds to indentify and prosecute perpetrators of health care fraud; conduct audits, investigations, and inspections that identify causes of and methods for preventing fraud, waste, and abuse; and protect the well-being of HHS program beneficiaries.

EMERGENCY PREPAREDNESS

(dollars in millions)

	2008	2009 ARRA*	2009 Omnibus	2010	2010 +/- 2009 Omnibus
Pandemic Influenza					
Agency Budgets	224	--	230	230	+0
PHSSEF	75	--	585	354	-231
Subtotal, Pandemic Influenza	299	--	815	584	-231
Terrorism Preparedness					
Agency Budgets	3,445	--	3,594	3,654	+61
PHSSEF	654	50	813	958	+146
Subtotal, Terrorism Preparedness	4,099	50	4,406	4,613	+206
Total, Emergency Preparedness	**4,399**	**50**	**5,222**	**5,197**	**-25**
Transfer of Funds					
Transfer of Project BioShield SRF from DHS to HHS*	--	--	--	1,264	+1,264

*American Recovery and Reinvestment Act of 2009 (Recovery Act)

**Total is an estimate based upon the current BioShield Special Reserve Fund (SRF) balance, and the planned procurements using the SRF in FY 2009

To protect our Nation from the threat of pandemic influenza, the FY 2010 Budget request includes $584 million in HHS-wide funding, including $276 million in no-year funding to complete the implementation the HHS Pandemic Influenza Plan. The FY 2010 Budget request also includes approximately $4.6 billion for bioterrorism and emergency preparedness activities across the Department. Funding for these activities is appropriated to the Public Health and Social Services Emergency Fund (PHSSEF) and directly to agencies.

PANDEMIC INFLUENZA

The FY 2010 Budget request for pandemic influenza preparedness includes $276 million in no-year funding for the next phase of the HHS Pandemic Influenza Plan. These funds will be used to continue the advanced development of antiviral drugs and cell-based and recombinant vaccines, and to ensure that the U.S. has sufficient vaccine manufacturing capacity in the event of a pandemic.

Reassortment of avian, swine and human influenza viruses has led to the emergence of a new strain of H1N1 influenza A virus, (2009-H1N1 flu) that is transmissible among humans, and is confirmed to have caused infections in humans in the United States, Canada, Spain, the United Kingdom, and Mexico where human deaths have occurred. On April 28, 2009 the President announced a supplemental request of $1.5 billion for the Federal response to this outbreak. These funds, in addition to the FY 2010 request and the remaining balances, will allow HHS to develop and distribute antivirals and vaccines, and personal protective equipment as well as conduct public health surveillance to track the outbreak.

The FY 2010 request includes no-year funds totaling $276 million to enhance the Nation's preparedness by investing in advanced development activities, which will help build vaccine production capacity, support next generation antivirals, and develop recombinant vaccine technology so HHS can continue to effectively respond to pandemic threats and protect Americans from influenza outbreaks.

In addition to this Budget request, a total of $308 million will fund ongoing annual pandemic influenza activities at FDA, CDC, NIH, and within the HHS Office of the Secretary (OS).

In FY 2006, Congress appropriated $5.6 billion in emergency funding for implementation of the HHS Pandemic Influenza Plan, through two FY 2006 emergency supplemental appropriations. An additional $507 million was

Increasing U.S. Vaccine Capacity

In January 2009, HHS awarded a contract to Novartis to support the completion of the first cell-based vaccine facility in the United States. The facility will be located in Holly Springs, North Carolina, and is expected to provide at least 25 percent of the needed surge capacity for an Influenza Pandemic. Cell-based vaccine production could more easily meet surge capacity needs because cells could be frozen and stored in advance of an epidemic or developed rapidly in response to an epidemic. Cell-based vaccine production also dramatically reduces the possibility for contamination and promises to be more reliable, flexible, and expandable than egg-based methods. The cell-based vaccine technology can also be used to make vaccines for seasonal influenza and other emerging infectious diseases.

appropriated in FY 2009. HHS has used these funds to advance the Nation's pandemic preparedness by expanding and diversifying domestic vaccine production and surge capacity; enlarging H5N1 pre-pandemic vaccine and antiviral drug stockpiles; supporting advanced development of cell-culture and antigen sparing influenza vaccines and new antiviral drugs; supporting advanced development of point-of-care clinical diagnostics; stockpiling medical supplies and ventilators; improving State and local preparedness; expanding risk communication efforts; enhancing FDA's regulatory science base; and expanding surveillance, research, and international collaboration efforts of CDC, NIH, and the HHS Office of Global Health Affairs.

These investments have been crucial in our response to the current 2009-H1N1 flu outbreak. At the time of the President's announcement, HHS had released 11 million courses of influenza antivirals to the States, deployed staff to regions with outbreaks in the U.S. and Mexico, provided community mitigation guidance, and expanded laboratory testing capacity across the U.S.

FY 2010 Pandemic Preparedness Priorities: HHS will continue efforts to detect and contain an emerging pandemic. The Budget request includes $158 million to continue to build vaccine production capacity, including development next generation recombinant influenza vaccines, expand the domestic pandemic vaccine manufacturing network, and start building of another cell-based influenza vaccine manufacturing facility in the U.S.

The Budget request also includes $53 million to continue support for advanced development of influenza antiviral drugs, which are critical to the response effort in the event of a pandemic. This support is towards new classes of antiviral drugs that are needed as currently circulating avian and human influenza viruses are naturally evolving and developing resistance to the current antiviral drugs in the stockpile. Also these funds will support the development of combination influenza antiviral drug therapies, which may include one or more currently U.S.-licensed antiviral drugs.

Lastly, continued development of next generation ventilators will be supported with $65 million to provide less expensive, more versatile and user-friendly forms of acute respiratory support devices.

In addition to the $276 million for development activities, a total of $308 million is requested in the budgets of the CDC, FDA, NIH, and OS to finance ongoing preparedness activities including:

- Expanding international and domestic surveillance and detection capabilities;
- Accelerating research and development of rapid diagnostic tests, to enable the accurate allocation of scarce countermeasures;
- Improving pandemic preparedness and response capabilities;
- Improving our Nation's ability to contain a potential pandemic influenza outbreak; and
- Supporting international efforts designed to strengthen the public health and vaccine manufacturing infrastructure, expand surveillance systems, and improve preparedness and response capabilities in countries with the highest numbers of confirmed H5N1 cases.

EMERGENCY PREPAREDNESS

(dollars in millions)

	2008	2009 Omnibus	2010	2010 +/- 2009 Omnibus
Pandemic Influenza:				
PHSSEF				
Vaccine:				
Achieve capacity and/or buy courses from egg-based manufacturer....	--	279	--	-279
Pandemic vaccine potency reagents library.....	--	--	5	+5
Cell based and recombinant vaccine development.....	--	--	50	+50
Advanced development of antigen sparing technologies.....	--	65	--	-65
Cell based vaccine production facility.....	--	--	63	+63
Vaccine fill/finish mfg warm base.....	--	--	40	+40
Subtotal, Vaccine	--	344	158	-186
Antivirals:				
Antiviral drug advanced development.....	--	123	53	-70
Subtotal, Antivirals	--	123	53	70
Ventilators:				
Next Generation Ventilators:.....	--	--	65	+65
Subtotal, Ventilators	--	--	65	65
Shared Responsibility:				
Countermeasures and PPE for HHS clinical and patient populations..	--	40	--	-40
Subtotal, Shared Responsibility	--	40	--	-40
Subtotal, No-Year Funding	--	507	276	-231
Office of the Secretary:				
Annual Request.....	75	78	78	+0.1
Subtotal, PHSSEF	75	585	354	-231
Agency Budgets				
CDC.....	155	156	156	--
FDA.....	35	39	39	+0.1
NIH.....	34	35	35	--
Subtotal, Agency Budgets	224	230	230	+0
Total, Program Level	**299**	**815**	**584**	**-231**

BIOTERRORISM AND EMERGENCY PREPAREDNESS

The FY 2010 Budget requests $4.6 billion for HHS bioterrorism and emergency response, an increase of $206 million over FY 2009. These funds are to protect Americans from a possible bioterrorist attack or other public health emergency, and are appropriated to the Public Health and Social Services Emergency Fund (PHSSEF) and directly to agency budgets.

PHSSEF ACTIVITIES

The FY 2010 Budget request for the PHSSEF bioterrorism and emergency preparedness activities is $958 million, a net increase of $146 million over FY 2009. The PHSSEF Budget request will support coordination of preparedness and response activities across HHS to improve the Nation's ability to prepare for, respond to, and recover from the adverse health effects of public health emergencies and disasters.

Assistant Secretary for Preparedness and Response: The Office of the Assistant Secretary for Preparedness and Response (ASPR) is lead for the Federal Government for public health and medical services response efforts under the National Response Framework (NRF), Emergency Support Function (ESF) #8. ASPR coordinates the bioterrorism and emergency preparedness activities of HHS agencies, develops and coordinates national policies and plans, provides program oversight, and serves as the Secretary's public health emergency representative to other Federal, State and local agencies.

HHS Cybersecurity

The Recovery Act of 2009 included $50 million to improve the security of the HHS IT infrastructure. HHS leadership embarked in early FY 2009 to define the requirements, scope, and desired security capabilities that would substantially improve the IT security posture of HHS as a whole. The Recovery Act funding will support agency-wide collaboration and supplements the resources and funds already being spent by the OPDIVs to improve security architecture. Funds will also support security tools to strengthen end user computer defense mechanisms against malware attacks, and the HHS Computer Security Incident Response Center which coordinates all efforts to monitor, detect, react, prevent, and mitigate attacks against HHS computer systems.

The Budget provides $305 million for advanced research and development of promising medical countermeasures, an increase of $30 million over FY 2009. Within ASPR, the Biomedical Advanced Research Development Authority (BARDA) is responsible for coordinating and administering Federal efforts to develop and procure vaccines and countermeasures to mitigate the medical consequences of potential chemical, biological, radiological and nuclear (CBRN) threat events. Funding in FY 2010 will be towards sustaining support of existing countermeasure development in the high priority areas for anthrax, enhanced biothreats, and acute radiation syndrome. These funds will support product development on previously-initiated development projects for selected countermeasure candidates. The funding for advanced research and development for FY 2010 will be provided through a transfer of funds from the remaining BioShield Special Reserve Fund (SRF). Additionally, all balances from the SRF will be transferred from the Department of Homeland Security to the PHSSEF, which will improve the execution of BioShield. The Budget request also includes $22 million to manage Project BioShield.

ASPR works with Federal, State, local and Tribal partners to ensure coordinated planning and response to bioterrorism and other public health and medical emergencies.

ASPR Budget request includes $36 million for Preparedness and Emergency Operations, an increase of $13 million over FY 2009. This funding will support improved regional coordination; interagency coordination for ESF #8; improve federal response capabilities; and work to address the special needs of at-risk populations. Included within this Budget request is $10 million to prepare for and respond to National Special Security Events and other planned and unplanned events. In FY 2010, ASPR will support the Winter Olympics, special Federal events, and other HHS response requirements as well as unforeseen response activities.

The Budget request also includes $56 million for the National Disaster Medical System (NDMS), an increase of $7 million over FY 2009, to implement emergency

readiness response improvements. The Budget request will support training, exercises, medical equipment and other deployable assets for over 100 Disaster Medical Assistance Teams, Disaster Mortuary Operational Response Teams, and other NDMS Teams to improve our Nation's capacity to respond to a terrorist attack or other public health emergency.

In the FY 2010 Budget, $10 million is included for a medical countermeasure dispensing demonstration project with the United States Postal Service (USPS). The USPS is a unique Federal entity because it reaches the homes of every American, and will be a significant asset in the distribution of MCMs to the public in the event of a public health emergency.

In FY 2010, $426 million is requested for the Hospital Preparedness Program, an increase of $32 million from FY 2009. Funding also provides $6 million for the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program.

The Budget provides $36 million for other ASPR activities, including $10 million for a new Emergency Care System program, which will improve the quality of emergency rooms at regional hospitals, and set national standards. These funds will also support operations, planning and communications, and coordination of international public health activities.

Cybersecurity: The Budget request provides $50 million for cybersecurity, an increase of $41 million, to protect the Department's information technology infrastructure from cyber attacks by providing continuous security monitoring for all HHS systems, assets, and services. This funding will build off of the $50 million provided in the American Recovery and Reinvestment Act of 2009, and will support a Department-wide collaboration to identify and address security vulnerabilities. Additionally, this will enhance Department-wide computer systems intrusion detection capabilities, security information event management systems, and network forensics capabilities. It also supports all HHS operating divisions' implementation, operation, and maintenance of security product solutions.

Medical Reserve Corps: Comprised of medical and public health volunteers, the Medical Reserve Corps contributes its expertise to local public health initiatives on an ongoing basis. The Budget request includes $13 million for the Medical Reserve Corps in FY 2010 to enhance the leverage of these efforts during a national catastrophic emergency.

Office of Security and Strategic Information: The Budget includes $5 million for the Office of Security and Strategic Information (OSSI), an increase of $1.6 million over FY 2009. OSSI is responsible for the development, maintenance, and operation of policy and programming in areas of physical security, personnel security, communications security and strategic information. OSSI is also the point of contact for all of HHS in working with the Director of National Intelligence.

Emergency Care Systems

The Emergency Care Coordination Center in ASPR works to improve the Federal coordination of in-hospital emergency medical care activities and to promote programs and resources that improve the delivery of our nation's daily emergency medical and mental health care. The Center is leading the $10 million Emergency Care Systems Initiative, which will develop national standards for emergency care performance measurement, categorization of emergency care facilities and protocols for the treatment, triage, and transport of pre-hospital patients. Additionally, this initiative will support a demonstration program to improve the quality of operations and outcomes and regional emergency medical systems.

HIGHLIGHTED BIOTERRORISM PREPAREDNESS ACTIVITIES

In addition to funding in the PHSSEF, another $3.7 billion in bioterrorism and emergency preparedness funding is requested directly in the appropriations for CDC, FDA, NIH, ACF, and OS.

Morbidity, loss of human life, and economic disruption caused by a terrorist attack or natural disaster could be substantially reduced through effective preparedness. The Budget request focuses on early detection and containment of an infectious outbreak, ensuring proper preparedness and response to an event, and having the countermeasures needed to treat and protect citizens against potential harmful exposures.

Detection and Containment: Quarantine stations improve CDC's capacity to respond to natural and intentional communicable disease emergencies of public health significance by catching disease at

the border and preventing it from spreading to the American public. The FY 2010 Budget provides $27 million to allow CDC to support the 25 quarantine stations located at airports across the country and in key international cities. This effort will also support more robust partnership activities with Federal agencies operating at the ports of entry, including Customs and Border Patrol. The CDC Budget request also provides $34 million for BioSense, the same as FY 2009.

FDA also plays a critical role in early detection through its food defense program. To protect our Nation's food supply, against intentional contamination, $217 million is included in this Budget request, an increase of $4 million over FY 2009, to support key food defense activities, including support for the Food Emergency Response Network. This funding builds on the $950 million in food safety funding which will increase and improve inspections, domestic surveillance, laboratory capacity, and domestic response to prevent and control foodborne illnesses.

Emergency Preparedness and Response: To minimize injury and loss of life resulting from a terrorist attack, our Nation must also have the ability to effectively prepare for and respond to such an event.

The FY 2010 Budget request provides $15 million, the same as FY 2009, to transform the Commissioned Corps into a force that is ready to rapidly respond to public health challenges and health care crises that can result from natural disasters, technological catastrophes, terrorist attacks, and other extraordinary needs.

The Budget request also includes $2 million for the Disaster Human Services Case Management planning and coordination effort in ACF. This program is a collaboration between ACF, ASPR, and the Federal Emergency Management Agency consistent with the command structure and reporting requirements in the National Incident Management Plan and the National Response Framework. A successful demonstration of this concept occurred during HHS' response to Hurricanes Gustav, when ACF was able to assist 647 families, including 1,924 individuals, by providing healthcare, mental health and human services needs.

HHS continues to demonstrate a strong commitment to prepare States and local public health departments and hospitals for public health emergencies and acts of bioterrorism. In FY 2010, $715 million is requested for such efforts in CDC, which is in addition to the $426 million requested in ASPR. The Upgrading State and Local Capacity Grants Program at CDC and the Hospital Preparedness Cooperative Agreement Grants Program at ASPR prepare States and local public health departments and hospitals for public health emergencies and acts of terrorism. HHS has invested of over $11 billion since September 11, 2001 on these efforts.

Protection and Treatment: Our bioterrorism readiness relies on quickly protecting Americans that have been exposed to a biological, chemical, or radiological threat agent and treating those who have become sick following an exposure. Our Nation's ability to counter bioterrorism ultimately depends on advancing biomedical science to develop next generation countermeasures.

The FY 2009 Budget request for NIH biodefense activities is $1.8 billion, which includes $97 million for radiological/nuclear

Performance Highlight

ASPR led HHS's integrated response to 42 public health emergencies and disasters including Hurricanes Gustav and Ike, and deployed nearly 2,000 personnel from HHS, DOD and other National Response Framework partners to Louisiana, Texas, Florida, Mississippi and Georgia to support medical and public health assets, including:

- 14 Federal Medical Shelters comprised of 250 beds each staffed by Federal and State personnel to provide basic care.
- 22 Disaster Medical Assistance Teams from the National Disaster Medical System to coordinate patient evacuations.
- 1 Disaster Mortuary Assistance Team and 1 Disaster Portable Morgue Unit to provide mortuary services for disinterred remains.
- 7 Rapid Deployment Force teams from the US Public Health Service to provide medical, mental health and public health staff augmentation.
- 3 Incident Response Coordination Teams to provide on-the-ground operational, logistical and administrative management.
- Over 300 medical personnel from the Veterans Health Administration which staffed Federal Medical Shelters in Ruston, Louisiana and Kelly Air Force Base, Texas.

and chemical countermeasures research. These funds will support basic and applied research on agents with bioterrorism potential which will ultimately lead to the availability of new or improved vaccines and therapies to protect or treat persons exposed to threat agents. This effort addresses a critical threat area to enhance our preparedness for a dirty bomb or other radiological or nuclear disaster.

Within HRSA, $5 million is included for the Preparedness Countermeasures Injury Compensation fund, established by the Public Readiness and Emergency Preparedness (PREP) Act. The program is authorized to provide compensation to individuals suffering from any unintended side effects of a covered countermeasure administered during a disaster. As of March 2009, there have been eight PREP Act declarations for pandemic influenza, anthrax, botulism, smallpox, and acute radiation syndrome.

In the event of a large scale terrorist attack, rapid access to large quantities of vaccines and medications is critical for saving lives. The FY 2010 President's Budget includes $596 million, a $25 million increase, for CDC's Strategic National Stockpile, a Federally-owned repository of countermeasures. Increased funds will help support the replacement of expiring products and increasing warehousing costs as the volume of the Stockpile increases, and additional products are added through Project BioShield.

EMERGENCY PREPAREDNESS

(dollars in millions)

	2008	2009 ARRA*	2009 Omnibus	2010	2010 +/- 2009 Omnibus
Bioterrorism and Emergency Preparedness:					
Direct Appropriations to Agency Budgets					
Centers for Disease Control and Prevention:					
Upgrading State and Local Capacity	746	--	747	761	+15
Biosurveillance Initiative	53	--	69	69	+0.03
Upgrading CDC Capacity	121	--	121	121	+0.05
Anthrax Research	8	--	8	--	-8
Strategic National Stockpile	552	--	570	596	+25
Subtotal, CDC	1,479	--	1,515	1,547	+32
National Institutes of Health:					
Biodefense Research	1,633	--	1,681	1,696	+16
Radiological/Nuclear Countermeasures Research	46	--	49	49	--
Chemical Countermeasures Research	49	--	48	48	--
Subtotal, NIH	1,728	--	1,777	1,793	+16
Food and Drug Administration:					
Food Defense	171	--	213	217	+4
Vaccines/Drugs/Diagnostics	56	--	67	68	+1
Physical Security	7	--	7	7	+0.1
Subtotal, FDA	234	--	287	292	+6
Adminstration for Children and Families:					
Disaster Human Services Case Management Initiative	--	--	--	2	+2
Health Resources Services Administration:					
Covered Countermeasures Fund	--	--	--	5	+5
Office of the Secretary:					
Revitalization of Commissioned Corps	4	--	15	15	--
Subtotal, Direct Appropriations	3,445	--	3,594	3,654	+61
Office of the Secretary, PHSSEF					
Assistant Secretary for Preparedness and Response (ASPR):					
Operations	10	--	13	13	--
Preparedness and Emergency Operations	17	--	22	36	+13
National Disaster Medical System (NDMS)	46	--	50	56	+7
Hospital Preparedness	423	--	394	426	+32
Emergency Care Systems	--	--	--	10	+10
Medical Countermeasure Dispensing	--	--	--	10	+10
Advanced Research and Development	102	--	275	305	+30
BioShield Management	21	--	22	22	+0.3
International Early Warning Surveillance	9	--	9	9	+0.1
Policy, Strategic Planning, and Communications	4	--	4	4	+0.1
Subtotal, ASPR	633	--	788	891	+103
Other Office of the Secretary:					
Office of Security and Strategic Information (OSSI)	3	--	3	5	+2
CyberSecurity	9	50	9	50	+41
Medical Reserve Corps	10	--	12	13	+0.2
Subtotal, Other Office of the Secretary	22	50	25	67	+43
Subtotal, PHSSEF	654	50	813	958	+146
Total, Bioterrorism and Emergency Reponse	**4,099**	**50**	**4,406**	**4,613**	**+206**
Transfer of Funds					
Transfer of Project BioShield SRF from DHS to HHS**	--	--	--	1,264	+1,264

*American Recovery and Reinvestment Act of 2009 (Recovery Act)

**Total is an estimate based upon the current BioShield Special Reserve Fund (SRF) balance, and the planned procurements using the SRF in FY 2009

ACRONYMS

A

ACF	Administrations for Children and Families
ADA	Americans with Disabilities Act
ADAP	AIDS Drug Assistance Program
ADUFA	Animal Drug User Fee Act
ADRC	Aging and Disability Resource Centers
AFDC	Aid to Families with Dependent Children
AFL	Adolescent and Family Life
AHRQ	Agency for Healthcare Research and Quality
AIDS	Acquired Immune Deficiency Syndrome
ALJ	Administrative Law Judge
AoA	Administration on Aging
ARRA	American Recovery and Reinvestment Act
ASD	Autism Spectrum Disorder
ASPR	Assistant Secretary for Preparedness and Response
ATSDR	Agency for Toxic Substances and Disease Registry

B

B&F	Buildings and Facilities
B.A.	Budget Authority
BARDA	Biomedical Advanced Research and Development Authority
BBA	Balanced Budget Act of 1997
BIPA	Medicare Benefits Improvement and Protection Act of 2000

C

CBRN	Chemical, Biological, Radiological and Nuclear
CCDBG	Child Care and Development Block Grant
CCDF	Child Care and Development Fund
CCES	Child Care Entitlement to States
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CMS	Centers for Medicare & Medicaid Services
CSBG	Community Services Block Grant
CSE	Child Support Enforcement
CTSA	Clinical and Translational Science Award
CY	Calendar Year

D

DEcIDE	Developing Evidence to Inform Decisions about Effectiveness
DME	Durable Medical Equipment
DOJ	Department of Justice
DRA	Deficit Reduction Act of 2005
DSH	Disproportionate Share Hospitals

E

EEOICPA	Energy Employees Occupational Illness Compensation Program Act
EHR	Electronic Health Record
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESRD	End Stage Renal Disease

F

FBI	Federal Bureau of Investigation
FCC	Federal Coordinating Council for Comparative Effectiveness Research
FDA	Food and Drug Administration
FFS	Fee-For-Service
FHA	Federal Health Architecture
FMAP	Federal Medical Assistance Percentage
FMS	Financial Management Services
FOHS	Federal Occupational Health Service
FPL	Federal Poverty Level
FPLS	Federal Parent Locator Service
FTE	Full Time Equivalent
FY	Fiscal Year

G

GDM	General Departmental Management
GINA	Genetic Information Non-Discrimination Act
GME	Graduate Medical Education
GSA	General Services Administration

H

HAI	Healthcare Associated Infections
HCFAC	Health Care Fraud and Abuse Control
HHS	Department of Health and Human Services
HI	Federal Hospital Insurance
HI	Hospital Insurance (Trust Fund)
HIE	Health Information Exchange
HIGLAS	Healthcare Integrated General Ledger Accounting System
HIPAA	Health Insurance Portability and Accountability Act
HITECH Act	Health Information Technology for Economic and Clinical Health Act
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HRSA	Health Resources and Services Administration

I

IHS	Indian Health Service
IME	Indirect Medical Education
IT	Information Technology

ACRONYMS

L

LIHEAP	Low Income Home Energy Assistance Program
LTC	Long-Term Care

M

MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MCH	Maternal and Child Health
MDUFA	Medical Device User Fee Act
MEPS	Medical Expenditure Panel Surveys
MIP	Medicaid Integrity Program
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MQSA	Mammography Quality Standards Act

N

NCRR	National Center for Research Resources
NDMS	National Disaster Medical System
NHIN	Nationwide Health Information Network
NHSC	National Health Service Corps
NIDDK	National Institute of Diabetes and Digestive and Kidney Diseases
NIEHS	National Institute of Environmental Health Sciences
NIH	National Institutes of Health
NIOSH	National Institute for Occupational Safety and Health
NMEP	National Medicare & You Education Program

O

OCR	Office for Civil Rights
OGHA	Office of Global Health Affairs
OIG	Office of Inspector General
OMH	Office of Minority Health
OMHA	Office of Medicare Hearings and Appeals
ONC	Office of the National Coordinator for Health Information Technology
OPDIV	Operating Division
ORR	Office of Refugee Resettlement
OS	Office of the Secretary
OSSI	Office of Security and Strategic Information
OWH	Office on Women's Health

P

PAHPA	Pandemic and All-Hazards Preparedness Act
PDP	Prescription Drug Plan
PDUFA	Prescription Drug User Fee Act
PHS	Public Health Service
PHSSEF	Public Health and Social Services Emergency Fund
PQRI	Physician Quality Reporting Initiative
PREP Act	Public Readiness and Emergency Preparedness Act
PSC	Program Support Center
PSSF	Promoting Safe and Stable Families

Q

QIO	Quality Improvement Organization

R

RAC	Recovery Audit Contractor
RHIO	Regional Health Information Organization
ROI	Return on Investment
RPG	Research Project Grant

S

SAMHSA	Substance Abuse and Mental Health Services Administration
SAS	Strategic Acquisition Service
SHIP	State Health Insurance Assistance Program
SNS	Strategic National Stockpile
SOW	Scope of Work
SSA	Social Security Administration
SSBG	Social Services Block Grant
SSF	Service and Supply Fund
SSI	Supplemental Security Income
STAFFDIV	Staff Division
STD	Sexually Transmitted Diseases
SGR	Sustainable Growth Rate

T

TAGGS	Tracking Accountability in Government Grants System
TANF	Temporary Assistance for Needy Families
TB	Tuberculosis
TMA	Transitional Medical Assistance
TWIIA	Ticket to Work and Work Incentives Improvement Act of 1999

U

UAC	Unaccompanied Alien Children

V

VFC	Vaccines for Children
VTC	Video Teleconference